2012

Uniform Medical Plan Classic

Certificate of Coverage

Uniform Medical Plan

Your health. Your plan. Your choice.

Self-insured by the State of Washington
Effective January 1, 2012

Printed under the direction of the Washington State Health Care Authority Public Employees Benefits Board

HCA 54-550 (10/11)

Directory

Customer Service	**1-888-849-3681** (TTY 711)	Monday–Friday 7 a.m. to 5 p.m. Pacific Time
Network Provider Directory	Use the provider search tool at **www.ump.hca.wa.gov** OR Call 1-888-849-3681 (TTY 711) LiveHelp via **www.myRegence.com**	Monday–Friday 7 a.m. to 5 p.m. Pacific Time
Medical Appeals and General Correspondence	Correspondence and Appeals PO Box 2998 Tacoma, WA 98401-2998	**Fax 1-877-663-7526**
Preauthorization (Medical Services)		**Fax 1-877-663-7526**
Online Access to Medical Claims	**www.myRegence.com**	
Claims Mailing Address (Medical) *(Member submitted)*	Regence BlueShield PO Box 3027 Salt Lake City, UT 84130-0271	**Fax 1-877-357-3418**
Prescription Drugs **Customer service, network pharmacies, preferred drug questions, complaints**	Washington State Rx Services	**1-888-361-1611**
Network mail-order pharmacies *See page 43 for more detailed prescription contact information*	Postal Prescription Services (PPS) BioScrip	**1-800-552-6694** **1-877-316-8921**
Paper claims or prescription drug appeals	Washington State Rx Services PO Box 40168 Portland, OR 97240-0168	**1-888-361-1611** **Fax 1-866-923-0412**
Drug preauthorization *Providers and pharmacists only*	Washington State Rx Services	**1-888-361-1611** **Fax 1-800-207-8235**
Eligibility and Enrollment **Monday–Friday** 8 a.m. to 5 p.m. Pacific Time	PEBB Benefits Services	**1-800-200-1004** Local 360-725-0440 **www.pebb.hca.wa.gov**
Address Changes	**Employees:** Contact your personnel, payroll, or benefits office	**All other members:** **1-800-200-1004** Local 360-725-0440
Tobacco Cessation **Monday–Friday** 8 a.m. to 6 p.m. Pacific Time	***Quit for Life***	**www.quitnow.net/ump/** **1-866-784-8454**

To obtain this booklet in another format (such as Braille or audio), call our Americans With Disabilities Act (ADA) Coordinator at 360-923-2714. TTY users may call this number through the Washington Relay Service by dialing 711.

How to Use This Book

Finding Information

- For general topics, check the Table of Contents; for example, "How to Find a Network Provider," "How Much Will I Pay for Prescription Drugs?"
- For specific subjects, check the Index starting on page 116.
- For an at-a-glance view of the most common benefits, see the "Summary of Benefits" (pages 8–13). The table also shows how much you will pay, any limits on the benefit (such as number of visits or dollar amount), whether preauthorization or notification is required, and the page numbers where you can find more about that benefit.
- To look up unfamiliar terms, see the "Definitions" section beginning on page 101.

Helpful Symbols

TIP: Indicates information that may be helpful in understanding a subject.

FOR MORE INFORMATION: Refers you to information found elsewhere.

ALERT! Important information you should know or something you need to do.

Special Section for Medicare Retirees

See our special section just for retirees enrolled in Medicare on pages 57–62. In addition, throughout the rest of the book look for the symbol below with accompanying blue text. This indicates information specific to Medicare retirees.

Information especially for Medicare retirees

If You Still Have Questions

If you have a specific question for which you can't find the answer:

- Use our online search function at **www.ump.hca.wa.gov**
- Call Customer Service at 1-888-849-3681 (Monday–Friday, 7 a.m. to 5 p.m. Pacific Time)

See the Directory page on the inside front cover of this document for more contact information.

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About Uniform Medical Plan Classic

Uniform Medical Plan Classic (UMP Classic) is a self-insured health plan offered through the Washington State Health Care Authority's Public Employees Benefits Board (PEBB) Program and administered by Regence BlueShield and Washington State Rx Services.

UMP Classic is available only to people eligible for coverage through the PEBB Program, including employees and retirees of state government and higher-education institutions, school district retirees, and employees of certain local governments and school districts that participate in the PEBB Program, as well as their eligible dependents.

This plan is designed to keep you and your family healthy, as well as provide benefits in case of injury or illness. Please review this booklet carefully so you can get the most from your health care benefits.

Online Services

You can access many services on the plan's website at **www.ump.hca.wa.gov**. Visit the site when you want to:

- Find a network provider or pharmacy.
- Find out what your prescription will cost.
- Order prescription refills through your pharmacy account.
- Search a knowledge base of plan benefits.
- Download or print documents and forms.
- Review Regence BlueShield medical policies.
- Review decisions on health technology.

You'll also find a link on the UMP website to **www.myRegence.com**, an award-winning website that helps you efficiently manage your health care by providing access to:

- Your Explanation of Benefits (medical claims processing details).
- Customer service via live chat (Live Help).
- Your general health assessment.
- Your personal health record.
- Health and wellness information.

Finding a Health Care Provider

If you are retired and enrolled in Medicare, see "Should I See a Network Provider?" on page 59 for information on choosing providers.

How to Find a Network Provider

UMP Classic members have access to Regence BlueShield network providers and Blue Cross and Blue Shield plan providers worldwide through the BlueCard® and BlueCard Worldwide programs, so your health coverage is with you wherever you are. Your access to care includes most acute care hospitals, urgent care and ambulatory surgery centers, physicians, and other health care professionals.

To find a network provider, use the Provider Search Tool on the UMP website at **www.ump.hca.wa.gov** or call Customer Service at 1-888-849-3681.

Services Received Outside the U.S.

The plan covers the same benefits outside of the United States (U.S.) if they are:

- Medically necessary (see definition on pages 108–109).
- Appropriate for the condition being treated.
- Not considered to be experimental or investigational by U.S. standards.
- Otherwise covered by the plan.

Foreign claims and any requested medical records must be translated into English with specific services, charges, drugs and dosage documented, along with the currency exchange rate. The plan does not pay for that translation and documentation. For coverage of drugs outside the U.S., see "Drugs Purchased Outside the U.S." on page 36.

ALERT! The plan does not cover prescription drugs ordered through foreign (non-U.S.) mail-order pharmacies.

Finding a Network Provider Outside the U.S.—BlueCard Worldwide®

BlueCard Worldwide coverage is also accessible to you. With BlueCard Worldwide, you have access to inpatient and outpatient hospital care and physician services when you're traveling or living outside the United States or any other areas covered by the domestic BlueCard program, as well as medical assistance and claims support services. When you need health care outside of the United States or any other areas covered by the domestic BlueCard program, follow these simple steps:

- Always carry your current plan identification card.
- If you need emergency medical care outside the United States or any other areas covered by the domestic BlueCard program, go to the nearest hospital.
- If you are admitted, call the BlueCard Worldwide service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177.

- For non-emergency medical care, call the BlueCard Worldwide service center. The service center will facilitate hospitalization if necessary at a contracted facility or make an appointment with a physician. BlueCard Worldwide service center staff are available to assist you 24 hours a day, 7 days a week.

You will only be responsible for out-of-pocket expenses such as any applicable deductible, copayment, coinsurance, and noncovered services for your inpatient care at a contracted hospital upon verification of eligibility and benefits by the BlueCard Worldwide service center. For inpatient care at a non-contracted hospital or all outpatient services, including outpatient hospital care or physician services, you will be responsible for paying the hospital or physician at the time of service and then must complete an international claim form and send it to the BlueCard Worldwide service center for reimbursement of covered services.

You can obtain an international claim form and find additional information about the BlueCard Worldwide program at **www.bcbs.com**.

TIP: To find a provider outside the United States, go to **http://provider.bcbs.com/** and click on the link "To locate healthcare providers outside of the U.S."

Why Choose a Network Provider?

Here's why you get the most from your plan when you choose network providers:

- You pay 15% of the allowed amount for most network services, after you pay your medical deductible.
- You pay nothing for covered preventive care services and immunizations when you see a network provider. See pages 26–27 for examples of services covered.
- A network provider won't bill you for more than the allowed amount.
- You won't have to file a claim if the plan is your primary coverage.

Note: You will have to pay for services or supplies that exceed benefit limits or are not covered, even if you see a network provider.

ALERT! Some providers are considered in-network at one practice location but not another. If you see a provider at a non-network location, services will be covered as non-network, even if the provider is network elsewhere. If you see a provider at a new or different location than usual, make sure he or she is a network provider at the alternate location as well.

Using Non-Network Providers Costs You Money

When you see a non-network provider:

- For services by non-network providers, you pay 40% of the allowed amount, **plus** any amount the non-network provider charges above the plan's allowed amount. This amount does not count toward your medical out-of-pocket limit.
- You still have to meet your medical deductible before the plan begins to pay. Any amount you pay above the plan's allowed amount does not count toward your medical deductible.
- You may have to pay upfront and send the claim to the plan yourself.

Note: Payment for non-network services may be sent to you or the provider. If you receive a check from the plan, if the payment should go to the provider, it will have both your name and the provider's.

TIP: The plan's allowed amount is the amount network providers agree to accept as payment in full (definition on pages 101–102). Non-network providers may charge more than this amount, and you are responsible for paying that difference.

Covered Provider Types

The plan pays for covered services only when performed by a covered provider type. All network providers are covered provider types. If you see a non-network provider that is not a covered provider type, the plan will not pay for any of the services received. As with all noncovered services, any payments made to a noncovered provider type will not apply toward your medical deductible or medical out-of-pocket limit. See the list of covered provider types at **www.ump.hca.wa.gov**.

TIP: A provider can be a covered provider type but not be a network provider. To find network providers, use the Provider Search Tool at **www.ump.hca.wa.gov**.

Comparing Network and Non-Network Payments

The chart below shows how much you pay for professional services when UMP Classic is your primary insurance. For these examples, assume you have paid your medical deductible and haven't reached your medical out-of-pocket limit.

Network Provider				
Billed Charge	**Allowed Amount**	**Must Provider Accept Allowed Amount?**	**Plan Pays**	**You Owe Provider**
$1,000	$900	Yes (Provider discount = $100)	$765 (85% x $900)	$135 ($900 – $765) (Member coinsurance: 15% of plan allowed)
Non-Network Provider				
Billed Charge	**Allowed Amount**	**Must Provider Accept Allowed Amount?**	**Plan Pays**	**You Owe Provider**
$1,000	$900	No (No provider discount)	$540 (60% x $900)	Member coinsurance (40% of plan allowed): $360 Difference between allowed and billed charge: $100 Total you pay: $460*

**This amount does not apply to your medical out-of-pocket limit.*

Please note that these are examples only, and may not reflect your specific situation.

What You Pay for Medical Services

Your Deductibles

A deductible is a fixed dollar amount you pay each calendar year before the plan begins paying most benefits. The medical deductible amount is $250 per person, with a maximum of $750 for a family of three or more people. When you first get services, you pay your provider the first $250 in charges. After you pay that first $250, the plan begins to pay benefits for your care. This applies to each covered family member, up to the $750 maximum.

You also pay a separate deductible for prescription drugs when you purchase Tier 2 and Tier 3 drugs. The prescription drug deductible is $100 per person, with a maximum of $300 for a family of three or more people, and does not apply to Value Tier or Tier 1 drugs. See page 33.

What Doesn't Count Toward My Medical Deductible?

The following out-of-pocket expenses do **not** count toward your $250 medical deductible:

- Services you pay for that aren't covered by the plan (see pages 47–51). **Note:** Not all services that the plan doesn't cover are listed here; you may call Customer Service at 1-888-849-3681 if you have questions about what's covered.
- Charges for services exceeding benefit maximums. For example, the maximum for vision hardware is $150 every two calendar years; charges over $150 do not count toward your medical deductible.
- Charges for services beyond benefit limits. For example, the annual benefit limit for acupuncture is 16 visits. Costs for visits you receive over 16 are not covered by the plan and do not count toward your medical deductible.
- Out-of-pocket costs for non-network provider charges exceeding the allowed amount.
- Your $200 per day inpatient hospital copayment.
- Your $75 per visit emergency room copayment.
- Prescription drug costs.

Which Services Are Exempt From the Medical Deductible?

You don't have to pay toward the medical deductible for these services before the plan pays:

- Preventive care and immunizations as described on pages 26–27.
- Routine vision care: exams, glasses, and contacts (page 30).
- Routine hearing care: exams and hearing aids (page 21).
- Prescription drugs (however, there is a prescription drug deductible that applies to Tier 2 and Tier 3 drugs only; see page 33).
- *Quit for Life* tobacco cessation program (page 29).
- Required second opinions (pages 27–28).

TIP: All services **not** listed above are subject to the medical deductible. This means that you must pay the first $250 of covered services before the plan begins to pay.

How Does the Medical Deductible Work With Families?

If you have three members in your family enrolled in UMP Classic, each family member must meet the $250 medical deductible for a family maximum of $750. Once any one person spends $250 that counts toward the deductible, the plan will begin paying benefits for that person. If your family has four or more members, when at least three members of the family reach their $250 per person deductible, no other family members are required to meet the deductible before services for those members are paid for by the plan.

ALERT! If you receive services with a benefit limit (such as chiropractic, massage therapy, or physical therapy) before meeting your deductible, those visits will count toward the benefit limit. For example, if you pay out of pocket for a chiropractor visit because you haven't met your deductible, that visit will count toward the maximum of 10 visits per calendar year. See definition of "Limited Benefit" on pages 106–107 for more information.

What Is Coinsurance?

Coinsurance refers to the percentage of the plan's allowed amount that you pay for most medical services and for prescription drugs, when the plan pays less than 100%.

How Much Coinsurance Do I Pay?

After you've paid your medical deductible, you pay the following percentages for most services:

- **For network providers:** 15% of the allowed amount.
- **For non-network providers:** 40% of the allowed amount. ***Note:*** Most non-network providers charge more than the allowed amount. You will be responsible for paying any amount a non-network provider bills that is above the allowed amount, in addition to your 40% coinsurance.

What Is a Copayment?

A copayment is a flat dollar amount you pay when you receive specific services, treatments, or supplies, including:

- Emergency room copay: $75 per visit. See "Emergency Room" on page 20 for details.
- Facility charges for services received while an inpatient at a hospital, mental health, chemical dependency, or skilled nursing facility: $200 per day copay (see below).

Inpatient Copay

For retirees enrolled in Medicare, the maximum inpatient copay is $600 ***per facility admission.*** There is no annual limit.

The **inpatient copay** is what you pay for inpatient services at a network facility—hospital, skilled nursing, mental health, chemical dependency: $200 per day for facility charges. Employees and retirees not enrolled in Medicare pay up to $600 maximum per calendar year; retirees enrolled in Medicare pay up to a $600 maximum per admission (no annual limit).

The inpatient copay does not count toward your medical deductible or medical out-of-pocket limit. You must pay this copay even if you have met your medical out-of-pocket limit (unless you have met your maximum annual copay).

NOTE: Professional charges, such as for physicians or lab work, may be billed separately and are not included in this copay.

When Do I Pay?

Most of the time, you pay ***after*** your claim is processed.

- You'll receive an Explanation of Benefits (EOB) from the plan that explains how much the plan paid the provider. (The Member Responsibility section of your EOB tells you how much you owe the provider.)
- The provider sends you a bill.
- You pay the provider.

Note: For some services, the provider may ask you to pay at the time of service. In these cases, you should check your Explanation of Benefits when it arrives to make sure that the amount you paid isn't higher than the amount shown in the Member Responsibility section.

What Is the Medical Out-of-Pocket Limit?

The medical out-of-pocket limit is the maximum total amount of coinsurance you pay to your providers for medical services during a calendar year (see below for expenses not included). Once you have reached this limit, the plan pays 100% of the allowed amount for covered medical services from network providers for the rest of the calendar year.

For employees and retirees not enrolled in Medicare and their dependents, this limit is $2,000 per person or $4,000 per family. For retirees enrolled in Medicare, the limit is $2,500 per person or $5,000 per family. "Family" means all members combined under one subscriber's account.

ALERT! Prescription drug costs do not count toward your medical out-of-pocket limit. The only limit to your drug cost is the prescription cost-limit at network pharmacies; see page 33. There is no limit to your annual out-of-pocket cost for prescription drugs.

The following costs do ***not*** count toward your medical out-of-pocket limit, and must be paid even after the limit has been met:

- Medical and prescription drug deductibles.
- Services and expenses that aren't covered.
- Charges for services exceeding benefit maximums. For example, the maximum for vision hardware is $150 every two calendar years; charges over $150 do not apply to this limit.
- Charges for services beyond benefit limits. For example, the benefit limit for chiropractic care is 10 visits. Costs for visits you receive over 10 do not count toward the out-of-pocket limit.
- Your member coinsurance (40%) paid to non-network providers, after your medical deductible is met.
- Charges that exceed the allowed amount (see pages 101–102). When a non-network provider's billed charge exceeds the plan's allowed amount, the difference between the allowed amount and the provider's billed charge does not apply to the medical out-of-pocket limit, except for dialysis and ambulance services.
- Emergency room copays.
- Inpatient copays (see page 6).
- Prescription drug costs: coinsurance and ancillary charges paid for prescription drugs. In the case of non-network pharmacies, any difference between the plan's allowed amount and the pharmacy's billed charges does not apply to this limit.

ALERT! Services by non-network providers are never paid at 100%. Even after you reach your medical out-of-pocket limit, you will still pay 40% coinsurance, plus any difference between the plan's allowed amount and the provider's billed charge.

Summary of Benefits

ALERT! Even if a provider orders a test or prescribes a treatment, the plan may not cover it. Please review this *Certificate of Coverage* or call Customer Service at 1-888-849-3681 if you have questions about benefits or limitations.

On the next several pages, you'll find a table summarizing your plan benefits. For a detailed list, see "Benefits: What the Plan Covers" starting on page 14. In addition, see "What the Plan Doesn't Cover" starting on page 47 for information about some services that are not covered. This plan covers only medically necessary services and supplies; see the definition on pages 108–109.

You must pay your medical deductible for most benefits before the plan begins to pay (except for those benefits exempt from this deductible; see page 5). Some benefits also have limits or maximums.

The percentage in the table refers to the amount you pay after you pay your medical deductible: this is your coinsurance (see page 6). These percentages are based on the plan's allowed amount; see definition on pages 101–102. The plan pays only up to the allowed amount. If you use non-network providers, you may be billed for the provider's charges over the allowed amount, in addition to your coinsurance and other costs. Network providers agree to accept the allowed amount as payment in full; non-network providers do not. See pages 2–4 for more information on your provider options.

There is no waiting period for coverage of pre-existing health conditions.

For more information on how this plan and Medicare work together, see "How Do UMP Classic and Medicare Work Together?" on page 57.

Summary of Benefits

All covered benefits are subject to the medical deductible unless noted. Percentages shown apply to the ***allowed amount*** (the fee accepted as payment in full by network providers; see definition on pages 101-102). *See pages 14-30 for benefits not listed below;* **bold** *page numbers indicate the most relevant information.*

Benefits	You pay for services by network providers *(percentage of the allowed amount)*	You pay for services by non-network providers *(percentage of the allowed amount)*	Preauthorization or notification[1] required?	See page(s)[2]
Ambulance Air, ground, or water	20%	20%	*Some services require preauthorization; call 1-888-849-3681*	**15**, 47, 50, 107
Chemical Dependency Treatment *Facility (hospital) charges and professional (doctor) charges may be billed separately.*				**16**, 49, 103, 115
• **Inpatient**	• **Facility:** Inpatient copay[3] • **Professional:** 15%	• **Facility:** 40%[4] • **Professional:** 40%[4]	Some services; see pages 44-45	
• **Outpatient**	• **Facility:** 15% • **Professional:** 15%	• **Facility:** 40%[4] • **Professional:** 40%[4]	Some services; see page 45	
Chiropractic Treatment See "Spinal and Extremity Manipulations" on page 13				
Diagnostic Tests, Laboratory, and X-Rays	15%	40%[4]	Computed Tomographic Angiography	**18**, 48, 49
Durable Medical Equipment, Supplies, and Prostheses	15%	40%[4]	A few supplies; see pages 44-45	**19-20**, 48, 49, 104

(continued on next page)

[1] ***Notification required:*** *Your provider must notify the plan when you receive services; see page 45.*

[2] *Some exclusions may apply to all benefits; see "What the Plan Doesn't Cover" on pages 47–51.*

[3] ***Inpatient copay:*** *What you pay for facility charges at network facilities; see "Inpatient Copay" on page 6.*

[4] *You will pay any difference between the plan's allowed amount and the provider's billed charge in addition to this percentage. This difference does not count toward your medical deductible or medical out-of-pocket limit (see pages 5–7 for details).*

[5] *Not subject to the medical deductible.*

Summary of Benefits, continued

All covered benefits are subject to the medical deductible unless noted. Percentages shown apply to the ***allowed amount*** (the fee accepted as payment in full by network providers; see definition on pages 101-102). *See pages 14-30 for benefits not listed below;* **bold** *page numbers indicate the most relevant information.*

Benefits	You pay for services by network providers *(percentage of the allowed amount)*	You pay for services by non-network providers *(percentage of the allowed amount)*	Preauthorization or notification[1] required?	See page(s)[2]
Emergency Room (ER) *You do not have to pay the ER copay if admitted to the hospital directly from the ER. If you didn't have access to network providers, you pay 15% of the allowed amount, plus any amount the provider charges over the allowed amount.*			No	**20**, 107
Facility (hospital) charges and professional (doctor) charges may be billed separately.	• **Facility:** 15% after you pay $75 copay per visit • **Professional:** 15%	• **Facility:** 15%[4] after you pay $75 copay per visit • **Professional:** 15%[4]		
Hospice Care *Subject to the medical deductible*	$0	40%[4]	No	**22**, 106, 114
• **Respite care** $5,000 lifetime maximum	$0	$0	No	
Hospital Services *Facility (hospital) charges and professional (doctor) charges may be billed separately.*				**22-23**, 48, 106
• **Inpatient**	• **Facility:** Inpatient copay[3] • **Professional**: 15%	• **Facility:** 40%[4] • **Professional:** 40%[4]	Notification[1]	
• **Outpatient**	• **Facility:** 15% • **Professional:** 15%	• **Facility:** 40%[4] • **Professional:** 40%[4]	Some services; see pages 44-45	

[1] ***Notification required:*** *Your provider must notify the plan when you receive services; see page 45.*

[2] *Some exclusions may apply to all benefits; see "What the Plan Doesn't Cover" on pages 47–51.*

[3] ***Inpatient copay:*** *What you pay for facility charges at network facilities; see "Inpatient Copay" on page 6.*

[4] *You will pay any difference between the plan's allowed amount and the provider's billed charge in addition to this percentage. This difference does not count toward your medical deductible or medical out-of-pocket limit (see pages 5–7 for details).*

[5] *Not subject to the medical deductible.*

All covered benefits are subject to the medical deductible unless noted. Percentages shown apply to the ***allowed amount*** (the fee accepted as payment in full by network providers; see definition on pages 101-102). *See pages 14-30 for benefits not listed below;* **bold** *page numbers indicate the most relevant information.*

Benefits	You pay for services by network providers *(percentage of the allowed amount)*	You pay for services by non-network providers *(percentage of the allowed amount)*	Preauthorization or notification[1] required?	See page(s)[2]
Mammograms				23
• **Screening mammograms**[5] *Beginning at age 40, one per calendar year*	$0	40%[4]	No	
• **Diagnostic mammograms**	15%	40%[4]	No	
Massage Therapy 16-visit maximum per calendar year	15%	No coverage for non-network providers	No	**23**, 49, 106-107
Mental Health Treatment *Facility (hospital) charges and professional (doctor) charges may be billed separately.*				**24**, 49
• **Inpatient**	• **Facility:** Inpatient copay[3] • **Professional:** 15%	• **Facility:** 40%[4] • **Professional:** 40%[4]	Some services; see pages 44-45	
• **Outpatient**	15%	40%[4]	Some services; see page 45	
Naturopathic Physician Services	15%	40%[4]	No	**24-25**, 47

(continued on next page)

[1] ***Notification required:*** *Your provider must notify the plan when you receive services; see page 45.*

[2] *Some exclusions may apply to all benefits; see "What the Plan Doesn't Cover" on pages 47–51.*

[3] ***Inpatient copay:*** *What you pay for facility charges at network facilities; see "Inpatient Copay" on page 6.*

[4] *You will pay any difference between the plan's allowed amount and the provider's billed charge in addition to this percentage. This difference does not count toward your medical deductible or medical out-of-pocket limit (see pages 5–7 for details).*

[5] *Not subject to the medical deductible.*

Summary of Benefits, continued

All covered benefits are subject to the medical deductible unless noted. Percentages shown apply to the ***allowed amount*** (the fee accepted as payment in full by network providers; see definition on pages 101-102). *See pages 14-30 for benefits not listed below;* **bold** *page numbers indicate the most relevant information.*

Benefits	You pay for services by network providers *(percentage of the allowed amount)*	You pay for services by non-network providers *(percentage of the allowed amount)*	Preauthorization or notification[1] required?	See page(s)[2]
Obstetric and Newborn Care— *See pages 26-27 for Well-Baby Care* *Facility (hospital) charges and professional (doctor) charges may be billed separately.*				**25**, 49, 50
• **Inpatient**	• **Facility:** Inpatient copay[3] • **Professional:** 15%	• **Facility:** 40%[4] • **Professional:** 40%[4]	No	
• **Outpatient**	15%	40%[4]	No	
Office Visits	15%	40%[4]	No	**26**, 49
Physical, Occupational, Speech, and Neurodevelopmental Therapy				**26**, 106-107
• **Inpatient:** 60 days maximum per calendar year for all types of therapy combined	Included in inpatient copay[3]	40%[4]	Some services; see page 45	
• **Outpatient:** 60-visit maximum per calendar year for all types of therapy combined	15%	40%[4]	No	
Prescription Drugs See pages 31-43				
Preventive Care *(including immunizations)*[5] *See pages 26-27 for examples of services covered under this benefit*				**26-27**, 48, 113, 114
	$0	40%[4]	No	

[1] ***Notification required:*** *Your provider must notify the plan when you receive services; see page 45.*

[2] *Some exclusions may apply to all benefits; see "What the Plan Doesn't Cover" on pages 47–51.*

[3] ***Inpatient copay:*** *What you pay for facility charges at network facilities; see "Inpatient Copay" on page 6.*

[4] *You will pay any difference between the plan's allowed amount and the provider's billed charge in addition to this percentage. This difference does not count toward your medical deductible or medical out-of-pocket limit (see pages 5–7 for details).*

[5] *Not subject to the medical deductible.*

All covered benefits are subject to the medical deductible unless noted. Percentages shown apply to the ***allowed amount*** (the fee accepted as payment in full by network providers; see definition on pages 101-102). *See pages 14-30 for benefits not listed below;* **bold** *page numbers indicate the most relevant information.*

Benefits	You pay for services by network providers *(percentage of the allowed amount)*	You pay for services by non-network providers *(percentage of the allowed amount)*	Preauthorization or notification[1] required?	See page(s)[2]
Spinal and Extremity Manipulations 10-visit maximum per calendar year	15%	40%[4]	No	**28**, 49, 106-107
Surgery *Facility (hospital) charges and professional (doctor) charges may be billed separately. Inpatient admissions may require notification; see page 45.*				**28**, 47, 49, 50, 102, 111
• **Inpatient**	• **Facility:** Inpatient copay[3] • **Professional:** 15%	• **Facility:** 40%[4] • **Professional:** 40%[4]	Some services; see pages 44-45	
• **Outpatient**	• **Facility:** 15% • **Professional:** 15%	• **Facility:** 40%[4] • **Professional:** 40%[4]	Some services; see pages 44-45	
Tobacco Cessation Program[5] *Quit for Life* program only	$0	Not covered	No	**29**, 50, 115
Vision Care (Routine)[5]				**30**, 106-107
• **Eye exams** (routine) One exam per calendar year	$0	40%[4]	No	
• **Vision hardware** (eyeglasses, contact lenses) *See page 30 for how the benefit works*	$150 maximum plan payment every two calendar years	$150 maximum plan payment every two calendar years	No	
Well Baby/Well Child Care *See Preventive Care on pages 26-27.*				

[1] ***Notification required:*** *Your provider must notify the plan when you receive services; see page 45.*

[2] *Some exclusions may apply to all benefits; see "What the Plan Doesn't Cover" on pages 47–51.*

[3] ***Inpatient copay:*** *What you pay for facility charges at network facilities; see "Inpatient Copay" on page 6.*

[4] *You will pay any difference between the plan's allowed amount and the provider's billed charge in addition to this percentage. This difference does not count toward your medical deductible or medical out-of-pocket limit (see pages 5–7 for details).*

[5] *Not subject to the medical deductible.*

Benefits: What the Plan Covers

Guidelines for Coverage

ALERT! The fact that a physician or other provider prescribes, orders, recommends, or approves a service or supply does not make it medically necessary (see pages 108–109).

For this plan to cover a service or supply, it must meet all of the following requirements:

- Be medically necessary.
- Follow the plan's coverage policies and preauthorization requirements.
- Follow coverage decisions made by the Washington State Health Technology Clinical Committee, which evaluates health technologies for effectiveness, safety, and cost.

Limits and exclusions may apply to plan benefits. See both the benefit description and "What the Plan Doesn't Cover," starting on page 47. Some services require preauthorization; see the list on pages 44–45 or call Customer Service to ask if a particular service is covered.

The following section describes the benefits provided by this plan. Be sure to read it carefully for important information that can help you get the most from your health coverage.

For Medicare Retirees: If you also have Medicare coverage, see "For Retirees Enrolled in Medicare" on pages 57–62.

Health Technology Clinical Committee

Under state law, UMP Classic must follow coverage decisions made by the Health Technology Clinical Committee (HTCC). If the Committee has determined that a service or treatment is not covered, then medical necessity is not an issue: it simply isn't covered (see exclusion 63 on page 50). If the Committee has determined that a service or treatment may be covered, then it will be covered only in cases where it meets the Committee's specific coverage criteria. Please note that these decisions may be made and take effect at any time during the plan year. You may view final decisions and ongoing reviews at **www.hta.hca.wa.gov**.

ALERT! If you receive services that are not covered under an HTCC decision, but would be under standard Regence coverage policy, the HTCC policy takes precedence. The plan does not cover the services, and you are responsible for all charges.

List of Benefits

Acupuncture

The plan covers 16 visits for acupuncture treatment per calendar year. See definition of "Limited Benefit" on pages 106–107.

Unless specifically stated otherwise, all benefits are subject to the medical deductible (see pages 5–6). How much you pay is described on pages 5–7. See also "Summary of Benefits" on pages 9–13 and "What the Plan Doesn't Cover" on pages 47–51. For services requiring preauthorization or notification, see pages 44–45.

Ambulance

TIP: You pay 20% for ambulance services, which must be medically necessary (see definition on pages 108–109). Ambulance services for personal or convenience purposes are not covered.

Ground Ambulance

Professional ground ambulance services are covered in a medical emergency:

- From the site of the medical emergency to the nearest facility equipped to treat the medical emergency (see definition of medical emergency on page 107).
- From one facility to the nearest other facility equipped to give further treatment.

In addition, when other means of transportation are considered unsafe due to your medical condition, the plan covers professional ambulance services:

- From one facility to another facility, for inpatient or outpatient treatment.
- From home to a facility.
- From a facility to your home.

Air or Water Ambulance

Air and water professional ambulance services are covered only when all of the following conditions are met:

- Ground ambulance is not appropriate.
- The situation is a medical emergency (see definition on page 107).
- Air or water ambulance is medically necessary (see definition on pages 108–109).
- Transport is to the nearest facility able to provide the care you need.

ALERT! If you travel outside the U.S., consider getting special insurance for air ambulance services. This plan covers air ambulance only to the nearest facility, such as a hospital, that can provide the care you need. Even if you or your doctor would rather you be sent to a facility closer to home, the plan will not cover the transportation.

Autism Treatment

To determine how a particular service, supply, or intervention is covered, please see that specific benefit. For example, speech or occupational therapy is addressed on page 26 under the "Physical, Speech, Occupational, or Neurodevelopmental Therapy" benefit; mental health coverage is found under "Mental Health Treatment" on page 24. If a specific benefit is subject to limits, such as number of visits, these limits apply to services, supplies, or interventions for an autism diagnosis the same as for any other diagnosis.

Bariatric Surgery

ALERT! The plan does not cover follow-up care or complications post bariatric surgery if the surgery was not covered under a PEBB plan (including lap band fills).

Bariatric (obesity) surgery is covered only in very specific clinical circumstances, including co-morbid conditions, and must be preauthorized by the plan. The plan will cover the surgery ***only*** if the patient meets all program requirements, including those for before and after surgery. The final decision as to whether the surgery will be covered is made by a plan Medical Director after all presurgical requirements are met. Approval will not be granted to patients who had previous bariatric surgery

within the last 10 years or any prior bariatric surgery covered by a health plan available through the Public Employees Benefits Board (PEBB) Program. The member must use providers and facilities designated by the plan.

The plan covers only certain types of bariatric surgery procedures. No other procedure will be considered for coverage.

TIP: Members who want to be evaluated for the obesity presurgical program must complete the questionnaire at **www.ump.hca.wa.gov.** If you do not have internet access, call Customer Service at 1-888-849-3681 to request a questionnaire.

Biofeedback Therapy

Biofeedback may be covered for headaches when preauthorized by the plan.

Chemical Dependency Treatment

ALERT! Admission to a Residential Treatment Center (RTC) must be preauthorized (see page 44).

Chemical dependency is defined as an illness characterized by a physiological or psychological dependence on a controlled substance or alcohol. Chemical dependency does not include dependence on tobacco, caffeine, or food.

Your provider must notify the plan upon admission when you receive the following services:

- Detoxification
- Inpatient admission
- Intensive Outpatient Program (IOP)
- Partial Hospitalization Program (PHP)

Inpatient

ALERT! Your provider must notify the plan upon admission when you receive inpatient services for chemical dependency treatment. Inpatient services for which the plan is not notified may not be covered. Inpatient chemical dependency treatment is subject to clinical review.

Services are considered "inpatient" when you are admitted to a facility. You pay an inpatient copay for facility charges at a network facility; see page 6 for details. Professional services may be billed separately from the facility charges. The plan pays for these services according to the network status of the provider, unless your condition is a medical emergency (see page 107).

For retirees enrolled in Medicare, the maximum inpatient copay is $600 ***per facility admission***. There is no annual limit.

Outpatient

Outpatient chemical dependency services are covered as any other medical service. The plan pays based on the allowed amount and the network status (network or non-network) of the provider.

Your provider must submit a treatment plan for more than 20 outpatient chemical dependency visits. If the plan has not received a treatment plan for review and a claim for visit 21 is submitted, claims processing will be delayed while we attempt to contact your provider to get the needed information. To avoid processing delays, your provider may submit a treatment plan earlier; the provider may call us at 1-888-849-3682 for details regarding what information is needed and how to submit it.

Unless specifically stated otherwise, all benefits are subject to the medical deductible (see pages 5–6). How much you pay is described on pages 5–7. See also "Summary of Benefits" on pages 9–13 and "What the Plan Doesn't Cover" on pages 47–51. For services requiring preauthorization or notification, see pages 44–45.

Chiropractic Physician Services

See "Spinal and Extremity Manipulations" on page 28.

Dental Services

Most dental services are not covered. For example, dental implants, orthodontic services, and treatment for damage to teeth or gums caused by biting, chewing, grinding, or any combination of these is not covered. However, your PEBB dental plan may cover these services.

For dental services that are covered by the plan, you pay 20% of the allowed amount. ***Only the following dental services are covered:***

General Anesthesia During a Dental Procedure

General anesthesia performed during a dental procedure is covered ***only*** when:

- It is provided by an anesthesiologist in a hospital or ambulatory surgery center.
- The charges for the hospital or ambulatory surgery center are covered by the plan (see "Dental Procedures Performed in a Hospital or Ambulatory Surgery Center" below).

Dental Procedures Performed in a Hospital or Ambulatory Surgery Center

Dental procedures performed in a hospital or ambulatory surgery center are covered ***only*** when any of the following conditions apply to the enrollee:

- Is under the age of 7 with a dental condition that cannot be safely and effectively treated in a dental office.
- Has a dental condition that cannot be safely and effectively treated in a dental office because of a physical or developmental disability.
- Has a medical condition that would put the enrollee at undue risk if the procedure were performed in a dental office.

Accidental Injuries

To receive coverage for repair of an accidental injury to natural teeth, the injury must be evaluated and a treatment plan developed and finalized within 30 days of the injury.

The actual treatment may extend beyond 30 days if your provider determines treatment should start later or continue longer. Treatment must be completed by the end of the calendar year following the accident.

The plan ***does not*** cover treatment that:

- Was not included in the treatment plan developed within the first 30 days following the accident.
- Extends past the end of the calendar year following the accident.

Oral Surgery

Only the following oral surgery procedures are covered, whether performed by a dentist or a medical professional:

- Excision of tumors or cysts of the jaw, cheeks, lips, tongue, gums, roof and floor of the mouth, or restorative surgery required by the excision.
- Incision of salivary glands or ducts.
- Obturator maintenance for cleft palate.
- Gum reduction for gingival hyperplasia due to Dilantin® or phenytoin use.
- Jaw reconstruction due to cancer.
- Treatment of a fracture or dislocation of the jaw or facial bones.

Note: *UMP Classic is not affiliated with the Uniform Dental Plan (UDP). If you are enrolled in UDP, please contact UDP for information.*

Unless specifically stated otherwise, all benefits are subject to the medical deductible (see pages 5–6). How much you pay is described on pages 5–7. See also "Summary of Benefits" on pages 9–13 and "What the Plan Doesn't Cover" on pages 47–51. For services requiring preauthorization or notification, see pages 44–45.

Diabetes Care Supplies

FOR MORE INFORMATION: If a health plan other than UMP Classic is your primary payer (see definition on page 113), claims for diabetes care supplies may be paid differently. See page 55 for more information.

Diabetic supplies listed below are covered under your plan's prescription drug benefit according to the designated tier in the *UMP Preferred Drug List*. To be covered, you must get a written prescription for these medications and supplies. To find out the tier of a product, see the online list or call Washington State Rx Services at 1-888-361-1611.

You save money and avoid having to submit your own claims when you purchase these diabetic supplies from a Washington State Rx Services network pharmacy. To find a network pharmacy, check the Washington State Rx Services online pharmacy locator at **www.ump.hca.wa.gov** or call 1-888-361-1611.

When covered under the prescription drug benefit, the following diabetes care supplies are covered under the tier listed in the *UMP Preferred Drug List*:

- Glucometers
- Test strips
- Insulin syringes
- Lancets

If Medicare is your primary health coverage, see page 58 for information on how claims for diabetes care supplies are processed.

Continuous glucose monitors must be preauthorized and are covered only under the medical benefit (see page 107).

See page 20 for coverage of insulin pumps and related supplies.

Diabetes Education

The plan covers diabetic self-management training and education, including nutritional therapy, by registered dieticians.

Diagnostic Tests, Laboratory, and X-Rays

This benefit covers tests that are appropriate for your diagnosis or symptoms reported by the ordering provider and must be medically necessary as defined on pages 108–109. If there are alternative diagnostic approaches with different fees, the plan will cover the least expensive, evidence-based diagnostic method. See pages 44–45 for a list of services requiring preauthorization.

ALERT! Some genetic tests are not covered; you may call Customer Service at 1-888-849-3681 to check.

Covered services include:

- Diagnostic laboratory tests, X-rays (including diagnostic mammograms), and other imaging studies.
- Electrocardiograms (EKG, ECG).
- Prostate cancer screening (prostate-specific antigen [PSA] testing): All PSA testing is covered under the medical benefit (subject to the medical deductible and coinsurance), even if billed as preventive.
- Skin allergy testing.

FOR MORE INFORMATION: See page 23 for information about how the plan covers mammograms.

Tests Not Covered

The plan does ***not*** pay for the following tests (this does not list all tests not covered by the plan):

- Carotid Intima Media Thickness testing.
- Computed Tomographic Colonography (CTC) (also called a virtual colonoscopy) for routine screening.
- Upright Magnetic Resonance Imaging (uMRI): Also known as "positional," "weight-bearing" (partial or full), or "axial loading."

Dialysis

For covered professional and facility services necessary to perform dialysis you pay:

- 15% for network facilities.
- 20% for non-network facilities.

Durable Medical Equipment, Supplies, and Prostheses

TIP: The plan covers durable medical equipment (DME) at the network benefit rate only if you get the equipment or supply from a network DME supplier or other network medical provider. Check the Provider Search Tool on the UMP website for network DME suppliers, or call Customer Service.

The plan does not cover equipment that costs more than less-costly equipment that serves the same medical purpose. Some items require preauthorization; see pages 44–45.

The durable medical equipment benefit covers services and supplies that are prescribed by a provider prescribing within his/her scope of practice, medically necessary, and used to treat a covered condition, including:

- Artificial limbs or eyes (including implant lenses prescribed by a physician and required as a result of cataract surgery or to replace a missing portion of the eye).
- Bilevel Positive Airway Pressure (BiPAP) devices.
- Bone growth (osteogenic) stimulators (requires preauthorization).
- Breast prostheses and bras as required by mastectomy. (See "Mastectomy and Breast Reconstruction" on page 23.)
- Casts, splints, crutches, trusses, and braces.
- Continuous Positive Airway Pressure (CPAP) devices.
- Diabetic shoes.
- Insulin pumps and related pump supplies.
- Ostomy supplies.
- Oxygen and rental equipment for its administration.
- Penile prosthesis when other accepted treatment has been unsuccessful and the impotence is:
  - Caused by a covered medical condition.
  - A complication directly resulting from a covered surgery.
  - A result of an injury to the genitalia or spinal cord.
- Rental or purchase (at the plan's option) of durable medical equipment such as wheelchairs, hospital beds, and respiratory equipment. (The combined rental fees cannot exceed full purchase price; may require preauthorization.)
- Wig or hairpiece to replace hair lost due to radiation therapy or chemotherapy for a covered condition, up to a lifetime maximum of $100. Other wigs and hairpieces are not covered.

The plan limits coverage of durable medical equipment to one item of that equipment and the accessories needed to operate the item. The plan also covers the repair or replacement of durable medical equipment due to

normal use or a change in the patient's condition (including the growth of a child). You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility. **NOTE:** UMP Classic does not cover replacement of lost, stolen, or damaged durable medical equipment.

ALERT! ***Orthotics:*** Items such as shoe inserts and other shoe modifications are ***not*** covered.

Insulin Pumps and Related Pump Supplies

Insulin pumps and related pump supplies are covered as durable medical equipment. For the highest benefit level, use a network durable medical equipment supplier. Go to the Provider Search Tool online and search for "Supplies and Equipment" under "Other Providers" or call Customer Service. **Note:** These supplies are not available through the mail-order pharmacies.

Emergency Room

ALERT! Medical emergencies treated at a non-network hospital will be paid at the network rate. You may be billed for any difference between the provider's billed charges and the allowed amount.

Facility charges for emergency room treatment are covered for diagnosis and treatment of an injury or illness covered by the plan. You must pay a $75 copay and coinsurance for each emergency room visit, in addition to any amount owed toward your medical deductible.

Charges for professional services (provided by doctors and other provider types) may be billed separately from facility (hospital or emergency room) charges. The plan pays these professional services based on the allowed amount, the provider's network status, payment rules, and services provided.

If your emergency room visit is not the result of a medical emergency (see definition on page 107), the plan may not pay for emergency services.

If you are admitted to the hospital directly from the emergency room, the $75 emergency room copay will be waived. However, you must pay the inpatient copay (see page 6).

Family Planning Services

The plan covers the following items and services:

- Contraceptive drugs (including Plan B, the "morning-after" pill).
- Barrier devices that require a prescription or fitting (including insertion and removal of IUDs; and fitting of cervical caps and diaphragms).

Hormonal contraceptives are covered under the prescription drug benefit according to the tier listed on the *UMP Preferred Drug List*. A barrier device may be covered under either the medical benefit or the prescription drug benefit, depending on how you get it. If your provider supplies the device, it is paid under the medical benefit. If you get a prescription for the device and fill it at a pharmacy, it is paid under the prescription drug benefit, as listed on the *UMP Preferred Drug List* (see chart on page 33).

The plan covers sterilization procedures, such as vasectomy, tubal ligation, or similar procedures, under the medical benefit. Reversal of voluntary sterilization is not covered.

Services related to voluntary and involuntary termination of pregnancy are covered. Treatments for infertility, including direct complications resulting from such treatment (for example, selective fetal reduction) are not covered.

Unless specifically stated otherwise, all benefits are subject to the medical deductible (see pages 5–6). How much you pay is described on pages 5–7. See also "Summary of Benefits" on pages 9–13 and "What the Plan Doesn't Cover" on pages 47–51. For services requiring preauthorization or notification, see pages 44–45.

Genetic Services

ALERT! Some genetic tests are not covered; you may call Customer Service at 1-888-849-3681 to check.

The plan covers medically necessary, evidence-based genetic testing services. Genetic testing of children to predict adult disease is not covered.

The plan does **not** cover genetic services for family planning purposes.

Hearing Care (Related to Diseases and Disorders of the Ear)

The plan covers treatment for diseases and disorders of the ear or auditory canal not related to routine hearing loss under the medical benefit. Hearing care benefit limits do not apply.

Hearing Exams and Hearing Aids

This benefit is exempt from the medical deductible, and includes the following services and supplies:

Hearing Exams (Routine)

One routine hearing exam is covered per calendar year. When you see a network provider, these services are paid at 100% of the allowed amount. However, if you see a non-network provider, you pay 40% of the allowed amount, plus any difference between the plan's allowed amount and the provider's billed charge.

Hearing Aids

The plan pays up to $800 per member every three calendar years for:

- Purchase of a hearing aid (monaural or binaural) prescribed as a result of an exam when necessary for the treatment of hearing loss, including:
  - Ear mold(s).
  - Hearing aid instrument.
  - Initial battery, cords, and other ancillary equipment.
  - Warranty and follow-up consultation within 30 days after delivery of hearing aid.
- Rental charges up to 30 days, if you return the hearing aid before actual purchase.
- Repair of hearing aid equipment.

You can see any provider for these services; the maximum benefit of $800 applies no matter where you shop.

Hearing Aid Items Not Covered

The following hearing-related items are not covered:

- Charges incurred after your coverage under this plan ends, unless you ordered the hearing aid before that date and it is delivered within 45 days after your coverage ended.
- Purchase of replacement batteries or other ancillary equipment, except those covered under terms of the initial hearing aid purchase.

Home Health Care

ALERT! See exclusion 26 on page 48 for services not covered by the plan.

UMP Classic covers medically necessary services provided and billed by a licensed home health agency for medical treatment of a covered illness or injury. These services must be part of a treatment plan written by your provider (such as a physician or advanced registered nurse practitioner [ARNP]). The provider must certify that you are homebound

and would require hospital or skilled nursing facility care if you did not receive home health care. The following services are covered:

- Visits for part-time or occasional skilled nursing care and for physical, occupational, and speech therapy.
- Related services such as occasional care (less frequently than daily visits, and under two hours per visit) from home health aides and clinical social services, provided in conjunction with the skilled services of a registered nurse (RN), licensed practical nurse (LPN), or physical, occupational, or speech therapist.
- Disposable medical supplies as well as prescription drugs provided by the home health agency.
- Home infusion therapy.

For services that may be covered under another benefit, such as nutritional counseling or follow-up care for bariatric surgery, see that benefit in this Certificate of Coverage for coverage rules and limitations. These limitations apply even if the services are provided in the home or by a home health provider.

Hospice Care (Inpatient, Outpatient, and Respite Care)

Services received from network providers are covered at 100% of the allowed amount. The plan covers hospice care for terminally ill enrollees for up to six months. Hospice care is subject to the medical deductible.

Respite Care

Respite care is continuous care of more than four hours a day to give family members temporary relief from caring for a homebound hospice patient. The plan covers these services at 100% once your deductible is met, up to a $5,000 lifetime limit.

Hospital Services

ALERT! Some hospital-based physicians (such as anesthesiologists and emergency room doctors) who work in a network hospital or other facility may not be network providers. If a non-network provider bills separately from the hospital and his or her billed charges are more than the allowed amount, you may be billed for the difference in addition to your member coinsurance. Check the Provider Search Tool online or call Customer Service for the network status of anesthesiologists and emergency room doctors in Washington State hospitals.

This benefit covers hospital accommodations and inpatient, outpatient, and ambulatory care services, supplies, equipment, and prescribed drugs to treat covered conditions. Room and board is limited to the hospital's average semiprivate room rate, except where a private room is determined to be necessary. Some services require preauthorization; see pages 44–45.

Services are considered "inpatient" when you are admitted as an inpatient to a hospital; your provider must notify the plan upon admission. You pay an inpatient copay for facility charges at a network facility; see page 6 for details. Professional services (such as lab tests, surgery, or other services) may be billed separately from the facility charges. The plan pays these services according to the network status of the provider, unless your condition is a medical emergency (see page 107). All covered professional services are paid based on the allowed amount.

For retirees enrolled in Medicare, the inpatient copay is $200 per day, with a maximum of $600 ***per inpatient admission***. There is no annual maximum.

Unless specifically stated otherwise, all benefits are subject to the medical deductible (see pages 5–6). How much you pay is described on pages 5–7. See also "Summary of Benefits" on pages 9–13 and "What the Plan Doesn't Cover" on pages 47–51. For services requiring preauthorization or notification, see pages 44–45.

Services are considered "outpatient" when you are not admitted to the hospital. Your cost depends on the services provided, such as lab tests, and the network status of the provider(s) involved in your care.

If you receive a service or device at a hospital, you may have to pay the difference between a higher cost service or device and a less expensive, medically appropriate alternative when one is available.

A network hospital can't charge you for the difference in cost between the standard and higher-cost item (unless you agreed in writing to pay before receiving the services).

If benefits change under the plan while you are in the hospital (or any other facility as an inpatient), coverage will be provided based on the benefit in effect when the stay began.

Mammograms

A mammogram is considered screening or diagnostic based on how it is billed by your provider.

Screening (Preventive) Mammograms

ALERT! "Baseline" (also called screening or preventive) mammograms for women under age 40 are not covered.

For women ages 40 and older, the plan covers only one screening mammogram per calendar year, not subject to the medical deductible. If you see a:

- **Network provider:** You pay nothing.
- **Non-network provider:** You pay 40% of the plan's allowed amount, plus any difference between the allowed amount and the provider's billed charge.

If you get more than one screening mammogram during a calendar year, the second one will not be covered.

Diagnostic (Medical) Mammograms

The plan pays for medically necessary mammograms to diagnose a medical condition under the medical benefit, subject to the medical deductible and coinsurance. Coverage of diagnostic mammograms is not related to age.

Massage Therapy

The plan covers no more than 16 massage therapy visits per calendar year. If you pay for visits before you meet your medical deductible, those visits count toward the 16-visit limit. See the definition of "Limited Benefit" on pages 106–107. You must have a prescription for massage therapy treatment from another provider, such as a physician.

ALERT! Only network massage therapists are covered. To find a network massage therapist, check the Provider Search Tool at **www.ump.hca.wa.gov** or call Customer Service.

Mastectomy and Breast Reconstruction

This benefit covers mastectomy as treatment for disease, illness, or injury, as well as:

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses.
- Physical complications of all stages of mastectomy.

Please note that you must use a covered provider type (see page 4) for services to be covered.

Unless specifically stated otherwise, all benefits are subject to the medical deductible (see pages 5–6). How much you pay is described on pages 5–7. See also "Summary of Benefits" on pages 9–13 and "What the Plan Doesn't Cover" on pages 47–51. For services requiring preauthorization or notification, see pages 44–45.

Mental Health Treatment

ALERT! Admission to a Residential Treatment Center (RTC) must be preauthorized (see page 44).

The plan covers mental health services for treatment of neuropsychiatric, mental, and personality disorders, including eating disorders. Marriage or family counseling is not covered.

Your provider must notify the plan upon admission when you receive the following services:

- Inpatient admission
- Partial Hospitalization Program (PHP)

Inpatient

ALERT! Inpatient mental health treatment is subject to clinical review.

Services are considered "inpatient" when you are admitted to a facility.

You pay an inpatient copay for facility charges at a network facility; see page 6 for details. Professional services (for example, doctors) may be billed separately from the facility charges. The plan pays for these services according to the network status of the provider, unless your condition is a medical emergency (see page 107). All covered professional services are paid based on the allowed amount.

For retirees enrolled in Medicare, the inpatient copay is $200 per day, with a maximum of $600 ***per inpatient admission***. There is no annual maximum.

Outpatient

Outpatient mental health services are covered as any other medical service. The plan pays based on the allowed amount and the network status (network or non-network) of the provider.

If your provider recommends more than 20 outpatient mental health visits, the plan will review your provider's treatment plan to determine if the following conditions are met:

- The purpose of the service is to treat or diagnose a medical condition;
- Outpatient services are the appropriate level of services considering the potential benefits of the services;
- The level of service is known to be effective in improving health outcomes; and
- The level of service recommended for your condition is cost-effective compared to alternative interventions including no intervention. See the definition of "Medically Necessary Services, Supplies, Drugs, or Interventions" on pages 108–109.

If the plan has not received a treatment plan for review and a claim for visit 21 is submitted, claims processing will be delayed while we attempt to contact your provider to get the needed information. To avoid processing delays, your provider may submit a treatment plan earlier; the provider may call us at 1-888-849-3682 for details regarding what information is needed and how to submit it.

Naturopathic Physician Services

ALERT! Naturopaths may recommend services that the plan doesn't cover. All services must meet the definition of medically necessary on pages 108–109 and normally be covered under the plan.

Services provided by naturopathic physicians are covered in the same way as for other providers. All services must be medically necessary to be covered.

Herbs and other nonprescription drugs, lotions, vitamins, and minerals are not

covered, even if your provider prescribes them.

Nutrition Counseling and Therapy

The plan covers up to three visits per lifetime for nutrition counseling and therapy services.

Obstetric and Newborn Care

Services for pregnancy and its complications are covered. Professional services covered include:

- Prenatal and postnatal care
- Amniocentesis and related genetic counseling and testing during pregnancy
- Prenatal testing (follows state regulations in Washington Administrative Code 246-680-020)
- Vaginal or cesarean delivery
- Care of complications resulting from pregnancy

For inpatient hospital charges related to a routine childbirth, you pay:

- Any remaining deductible for the mother.
- The mother's inpatient copay. (see page 6).
- Coinsurance for professional services for the mother while hospitalized.
- The deductible for the newborn; however, if only preventive care services (see pages 26–27) are billed for the newborn, you will not pay the baby's deductible.

For non-routine hospitalization of the newborn, you will also pay a separate inpatient copay for the newborn.

A newborn dependent of an enrollee is covered from birth to at least 21 days following birth. See "Adding a New Dependent to Your Coverage" on this page for what you need to do for continued coverage.

If your obstetric care began while covered under another health plan, and the providers are not part of the plan network, call Customer Service.

Some prenatal, newborn, and well-baby care services are covered at 100% when you see a network provider. See "Preventive Care" on pages 26–27 for more information.

See page 41 for coverage of prenatal vitamins.

Limitations on Ultrasounds During Pregnancy

Note: ***The following limits do not apply to high-risk pregnancies. For example, a multiple pregnancy is considered high risk.***

Ultrasounds during pregnancy are covered as follows:

- One in week 13 or earlier.
- One during weeks 16-22.

Additional ultrasound(s) may be covered when medically necessary for the diagnosis, management, and treatment of complications of pregnancy on appeal; see pages 69–74.

Adding a New Dependent to Your Coverage

If the birth or adoption of a child increases your premium, you must submit the appropriate enrollment form and any necessary documents no later than 12 months after the birth or adoption to:

- **Employees:** Your personnel, payroll, or benefits office.
- **Retirees:** PEBB Program at 1-800-200-1004.

For subsequent children whose enrollment doesn't affect your premium, you should submit the appropriate enrollment forms and any necessary documents to the appropriate office (see above) no later than 60 days after the birth or adoption.

Unless specifically stated otherwise, all benefits are subject to the medical deductible (see pages 5–6). How much you pay is described on pages 5–7. See also "Summary of Benefits" on pages 9–13 and "What the Plan Doesn't Cover" on pages 47–51. For services requiring preauthorization or notification, see pages 44–45.

Office Visits

The plan pays for office visits for covered conditions under the medical benefit (see page 107). Preventive care visits to network providers as described beginning in the next column are covered at 100% and are not subject to the medical deductible.

Physical, Occupational, Speech, and Neurodevelopmental Therapy

The plan covers inpatient and outpatient services to improve or restore function lost due to:

- An acute injury or illness.
- Worsening or aggravation of a chronic injury.
- A congenital anomaly (such as cleft lip or palate).
- Conditions of developmental delay, including autism.

You must have a prescription for the above therapies from another provider, such as a physician.

Inpatient Services

Your provider must notify the plan when you are admitted to a facility for physical, occupational, speech, and neurodevelopmental therapy services. The plan covers rehabilitation therapy services provided during inpatient hospitalization up to 60 days per calendar year (see definition of "Limited Benefit" on pages 106–107). You must pay the inpatient copay (see page 6) and your coinsurance for inpatient services.

Outpatient Services

The plan covers outpatient physical, occupational, speech, and neurodevelopmental therapy services up to 60 visits per calendar year, counting all types of therapies listed here (see definition of "Limited Benefit" on pages 106–107).

For the purposes of this benefit, developmental delay (see definition on page 103) means a significant lag in achieving skills such as:

- Language (speech, reading, writing)
- Motor (crawling, walking, feeding oneself)
- Cognitive (thinking)
- Social (getting along with others)

Prescription Drugs

Please see "Your Prescription Drug Benefit" starting on page 31.

Preventive Care

ALERT! This benefit covers ***only*** services that meet the criteria below. If you receive services during a preventive care visit that do not meet these requirements, they will not be covered as preventive care. Instead, when medically necessary, the services are subject to the medical deductible and are covered under the specific benefit the charges apply to (such as diagnostic tests, laboratory, or X-rays). If your provider bills for your visit as treatment for a medical condition instead of an annual physical exam, the services may be covered under the medical benefit and subject to the deductible and coinsurance.

You don't have to meet your medical deductible before the plan pays for services covered under the preventive care benefit. When you see a network provider for these services, you pay nothing. If you see a non-network provider, you pay 40% of the allowed amount (definition on pages 101–102), plus any difference between the allowed amount and the provider's billed charge.

Services designated with an A or B rating by the United States Preventive Services Task

Force (USPSTF) are covered under the preventive care benefit when received from a professional provider or facility. (See the website at **www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.**)

Examples of services covered under the preventive care benefit include:

- Preventive visits such as well-baby care, annual physical exams, and routine screenings for women.
- Radiology and lab tests such as screening mammograms (see page 23).
- Screening procedures such as colonoscopy.
- Immunizations as specified under "Covered Immunizations" below.
- Certain screening tests performed during pregnancy; see page 25 for more on prenatal care.

You may call Customer Service at 1-888-849-3681 to ask if a service is covered as preventive.

Note: Prostate cancer screening (prostate-specific antigen [PSA] testing) is not covered under the preventive care benefit, but is covered as a medical benefit (subject to the medical deductible and coinsurance).

ALERT! Follow-up visits or tests are not covered under the preventive care benefit. If the test or visit is normally covered by the plan and is medically necessary, the plan pays under the medical benefit (see definition on page 107).

Covered Immunizations

The plan covers immunizations as included on the applicable immunization schedule (children, adolescents, adults) for U.S. residents by the Centers for Disease Control and Prevention (CDC). For the list of covered immunizations, see the UMP website or call Customer Service at 1-888-849-3681. Immunizations covered under the preventive care benefit are not subject to the deductible. Immunizations given by the providers listed under "Where Can I Get Immunizations?" (see below) are paid under the preventive care benefit. If you see a non-network provider for covered immunizations, you pay 40% of the allowed amount, plus any difference between the allowed amount and the provider's billed charge.

FOR MORE INFORMATION: For a list of immunizations covered as preventive, see links to the CDC schedules on the UMP website or call 1-888-849-3681.

Where Can I Get Immunizations?

You can receive immunizations at the network rate (free, if covered under the preventive care benefit) at a:

- Network provider.
- Network vaccination pharmacies (see definition on page 109; check the UMP website or call 1-888-361-1611 to find a pharmacy).
- Public health department.

Note: The plan does not cover immunizations for travel or employment, even when recommended by the CDC or required by travel regulations.

TIP: Flu shots are covered as included on the applicable CDC immunization schedule.

Second Opinions

This benefit covers:

- **Second opinions you choose to get.** The plan covers these under the medical benefit subject to the medical deductible and coinsurance.
- **Second opinions required by the plan.** The plan covers these at 100% (you don't

pay toward your medical deductible or coinsurance). If you don't get a second opinion when required by the plan, coverage for services may be denied.

Skilled Nursing Facility

Services must be preauthorized by the plan before you are admitted to a skilled nursing facility; see page 45.

This benefit covers skilled nursing facility charges for services, supplies, and room and board, including charges for services such as general nursing care made in connection with room occupancy. UMP Classic covers up to 150 days per calendar year. Room and board is limited to the skilled nursing facility's average semiprivate room rate, except where a private room is determined to be necessary.

Skilled nursing facility confinement that is primarily convalescent or custodial in nature is not covered.

For Medicare Retirees: Medicare limits treatment in a skilled nursing facility to 100 days per year. If Medicare is your primary coverage, this plan covers your first 100 days in a skilled nursing facility as your secondary insurer. Those 100 days count against the 150-day maximum allowed by UMP Classic.

After you have reached your Medicare maximum of 100 days, UMP Classic covers an additional 50 days if services are medically necessary and meet the plan's criteria for skilled nursing facility coverage.

Spinal and Extremity Manipulations

Up to 10 visits per calendar year for manipulations (adjustments) of the spine and extremities (arms and legs) are covered. When you have reached your 10-visit limit, no further payment for manipulations (adjustments) of the spine and extremities (arms and legs) will be made.

Visits that count toward your medical deductible also count toward your 10-visit limit (see "Limited Benefit" on pages 106–107).

Surgery

ALERT! Even if your doctor is in the network, the facility or other providers such as anesthesiologists might not be. Make sure you confirm that all of the providers who will participate in your care and the facility are in the network before you receive services. Non-network providers and facilities can bill you for all charges not paid by the plan, while network providers and facilities agree to accept the payment amounts negotiated by the plan, resulting in significant savings for you.

The plan pays for covered surgical services according to the network status of the provider (see page 4 for coinsurance amounts). The surgeon and other professional providers may bill separately from the facility.

See pages 44–45 for a list of services that require preauthorization. In addition, your provider must notify the plan when you receive certain services, including admission as an inpatient; see list on page 45. Call Customer Service if you have questions.

If services are inpatient (see definition of "Inpatient Stay" on page 106), you will also pay an inpatient copay for facility charges at a network facility (see page 6).

The plan covers the following services as outpatient:

- Outpatient surgery at a hospital.
- Surgery and procedures performed at an ambulatory surgery center.
- Short-stay obstetric (childbirth) services (released within 24 hours of admission).

Telehealth Services

The plan covers telemedicine for audio and video communication between the distant site physician, patient, and consulting practitioner under the medical benefit (see page 107). The originating site must be a rural health professional shortage area as defined by the Centers for Medicaid & Medicare Services (CMS).

This benefit does not include:

- Email or facsimile transmissions between doctor and patient.
- "Store and forward" technology (transmission of medical information reviewed at a later time by physician or practitioner at distant site).
- Installation or maintenance of any telecommunication devices or systems.
- Home health monitoring.

Temporomandibular Joint (TMJ) Treatment

Surgical treatment of temporomandibular joint (TMJ) disorders is covered and must be preauthorized by the plan. Medical, dental, or other types of treatment for TMJ disorders are not covered.

Tobacco Cessation Program

The plan covers tobacco cessation services ***only*** when you are enrolled in the *Quit for Life* tobacco cessation program. No other stop smoking services are covered. *Quit for Life* provides phone counseling, online communications, nicotine replacement therapy, and educational materials to help you quit using tobacco. Enroll by calling 1-866-784-8454 or go online to **www.quitnow.net/ump/.**

These services are covered at 100%. You do not pay toward your medical deductible or coinsurance.

ALERT! Only nicotine products supplied by *Quit for Life* are covered. If you choose to get a product that *Quit for Life* doesn't supply, you will have to pay the entire cost out of pocket.

When recommended by your *Quit for Life* counselor, the following medications are free to you:

- Nicotine patches, lozenges, or gum.
- Prescription drugs identified in the *UMP Preferred Drug List* as covered when preauthorized by *Quit for Life*.

Nicotine patches, lozenges, or gum will be sent to you by *Quit for Life* at no cost to you. Nicotine replacement therapy is covered ***only*** when supplied directly by *Quit for Life*. You cannot purchase these products and get reimbursed later.

To receive coverage for prescription drugs, you must:

- Be participating in *Quit for Life*.
- Get preauthorization from your *Quit for Life* counselor.
- Go to your doctor and request a prescription.

Please allow three business days after *Quit for Life* approves coverage before filling your prescription. Prescription drugs for tobacco cessation are covered only at network (retail and mail-order) pharmacies.

ALERT! See the current *UMP Preferred Drug List* online for drugs covered under this benefit. If your provider prescribes a noncovered drug for tobacco cessation, you will have to pay the full cost. **Note:** When a generic drug becomes available, the brand-name drug is not covered.

Unless specifically stated otherwise, all benefits are subject to the medical deductible (see pages 5–6). How much you pay is described on pages 5–7. See also "Summary of Benefits" on pages 9–13 and "What the Plan Doesn't Cover" on pages 47–51. For services requiring preauthorization or notification, see pages 44–45.

Transplants

You must receive preauthorization from the plan for all transplants (except kidney and cornea). This benefit covers services related to transplants, including professional and facility fees for inpatient accommodation, diagnostic tests and exams, surgery, and follow-up care.

Donor Coverage

If a UMP Classic member receives an organ from a live donor, UMP Classic pays the donor's covered expenses as primary, regardless of any other coverage the donor may have. Covered donor expenses include costs to remove the donor's organ and treat complications directly resulting from the donor's surgery.

TIP: You don't need to preauthorize kidney or cornea transplants.

Vision Care (Related to Diseases and Disorders of the Eye)

The plan covers treatment for diseases and disorders of the eye that are not part of a routine vision exam under the medical benefit. Orthoptic therapy is not covered except for the diagnosis of strabismus, a muscle disorder of the eye. LASIK surgery is not covered.

Vision Care (Routine)

TIP: Limits to vision care benefits apply per enrollee. Each enrolled member in your family is entitled to one routine eye exam per calendar year, and $150 in vision hardware every two calendar years.

This benefit is exempt from the medical deductible and includes:

Eye Exams

The plan covers one routine eye exam for each enrollee per calendar year, including contact lens fitting fees. You pay nothing for services by a network provider. For a non-network provider, you pay 40% of the allowed amount, plus any difference between the allowed amount and the provider's billed charge (see definition of "Preventive Care" on page 113).

Hardware (Eyeglasses and Contact Lenses)

The plan pays up to $150 every two calendar years for prescription eyeglass lenses, frames, and contact lenses, including repairs. This $150 limit is renewed on January 1 of even years (2012, 2014, etc.). Any unused amount does not carry over into the next even plan year. The plan will not pay more than your actual cost for these items and services. You are responsible for any costs above the $150 limit.

You can buy your vision hardware anywhere; the maximum benefit of $150 applies no matter where you shop. If you go to a provider that does not bill the plan directly, you can submit a claim for glasses or contacts; see "Billing & Payment: Filing a Claim" starting on page 63 for instructions.

TIP: If UMP is your secondary plan and your primary plan is not Medicare, contact Customer Service before submitting a secondary claim for vision hardware.

Unless specifically stated otherwise, all benefits are subject to the medical deductible (see pages 5–6). How much you pay is described on pages 5–7. See also "Summary of Benefits" on pages 9–13 and "What the Plan Doesn't Cover" on pages 47–51. For services requiring preauthorization or notification, see pages 44–45.

Your Prescription Drug Benefit

ALERT! If Medicare is your primary coverage, see "How UMP Classic Prescription Drug Coverage Works With Medicare" starting on page 61 for important information.

See page 43 for prescription drug contact information.

Your plan's drug benefit is administered and coordinated by a partnership of companies known as Washington State Rx Services. These companies are:

- **ODS**—Administration and customer service.
- **MedImpact Healthcare Systems Inc.**—Pharmacy network management and prescription drug claims processing.
- **Mail-order prescription drugs:**
  - PPS (Postal Prescription Services)
  - BioScrip
- **Specialty drug pharmacy**—BioScrip.

When you have questions regarding your prescription drug coverage or need assistance finding a network pharmacy, call Washington State Rx Services at 1-888-361-1611. Contact the mail-order or specialty pharmacy directly for assistance placing or tracking prescription orders.

TIP: The *UMP Preferred Drug List* is available at **www.ump.hca.wa.gov**. You can also check drug prices online with the Prescription Price Check tool.

What Drugs Are Covered? The *UMP Preferred Drug List*

ALERT! Not all drugs are listed on the *UMP Preferred Drug List*. If your drug isn't listed, call 1-888-361-1611.

The *UMP Preferred Drug List* lists the following:

- If a drug is covered by the plan.
- How much you will pay for a drug based on the drug's tier and whether it has an ancillary charge (see pages 33–34).
- If the drug must be preauthorized (see "Preauthorization" on page 37).
- If the drug must be purchased from the plan's specialty pharmacy (see pages 37–38).
- If there are any limits on a drug's coverage (see pages 37–39 under "Limits on Your Prescription Drug Coverage").
- If there are less expensive alternatives.

TIP: The *UMP Preferred Drug List* is sometimes called a "formulary."

The *UMP Preferred Drug List* is updated online weekly. However, a drug may change tier or the ancillary charge may apply at any time, in particular when a generic equivalent becomes available. You can look up your prescription drugs online at **www.ump.hca.wa.gov** or by calling Washington State Rx Services. New drugs may not be covered during the first 180 days they are available. To check if a new drug is covered, call Washington State Rx Services at 1-888-361-1611.

ALERT! When a generic equivalent for a brand-name drug becomes available, the brand-name drug *immediately* becomes Tier 3 with an ancillary charge. Always ask your doctor to allow substitution on your prescriptions to save you money.

Who Decides Which Drugs Are Preferred?

The *UMP Preferred Drug List* is based in part on recommendations from the Washington State Pharmacy & Therapeutics Committee (P&T Committee) and the Washington State Rx Services P&T Committee. These P&T Committees represent an independent group of practicing health care providers.

If a drug has not yet been reviewed by the Washington State P&T Committee, the plan follows recommendations from a Washington State Rx Services P&T Committee to decide tier status.

ALERT! A drug may be designated as Tier 3 (nonpreferred brand name) even if no generic alternative is available.

How Much Will I Pay for Prescription Drugs?

The amount you pay for your prescription depends on the drug's tier and where you purchase your prescriptions. The *UMP Preferred Drug List* classifies drugs into four tiers:

- Value Tier drugs are specific high-value generic medications used to treat certain chronic conditions.
- Tier 1 are primarily low-cost generic drugs.
- Tier 2 are preferred drugs (brand-name and some generics).
- Tier 3 are nonpreferred drugs.

In general, Value Tier and Tier 1 drugs are the least expensive for you and Tier 3 are the most expensive. Even though Tier 3 drugs are called "nonpreferred," the plan still covers them, but you pay more.

You can find a drug's tier by checking the searchable *UMP Preferred Drug List* at **www.ump.hca.wa.gov** or by calling Washington State Rx Services at 1-888-361-1611. You can purchase up to a 90-day supply for most drugs, except for specialty drugs.

You pay for all covered prescription drugs based on coinsurance, which is a percentage of the drug's cost. If your prescription drug costs more than $1,500, it must be reviewed by the plan before being filled. Your provider can call Washington State Rx Services at 1-888-361-1611 to request coverage.

To check your cost:

- Call Washington State Rx Services at 1-888-361-1611, or
- Use the Prescription Price Check tool at **www.ump.hca.wa.gov**.

See the table on page 33 for how much you pay for each of the drug tiers. Using Value Tier and Tier 1 drugs reduces prescription costs for both you and the plan. Generic drugs have the same active ingredient as their brand-name counterparts and are usually less expensive.

Prescription Drug Deductible

You don't pay any deductible for Value Tier or Tier 1 drugs. If you get only Value Tier and Tier 1 drugs during the year, you won't need to pay the prescription drug deductible.

You must pay a prescription drug deductible to the pharmacy for purchases of Tier 2 and Tier 3 (brand-name) prescription drugs before the plan pays toward these prescriptions. This deductible is $100 per person (a maximum of $300 for a family of three or more people covered under the same account). You pay the deductible ***plus*** any applicable coinsurance, up to the cost of the drug. The deductible applies regardless of where you purchase your prescription. Once you meet the deductible, the plan pays benefits for the rest of the calendar year.

FOR MORE INFORMATION If you use specialty drugs, see "Specialty Drugs" on pages 37–38 for cost and rules regarding coverage, including specific information regarding the prescription cost-limit for specialty drugs.

What counts toward my prescription drug deductible?

- Amounts paid toward Tier 2 and Tier 3 covered prescription drugs.
- Amounts paid toward supplies designated as Tier 2 or Tier 3 and covered under the prescription drug benefit.

What doesn't count toward my prescription drug deductible?

- Any applicable ancillary charge (see page 34).
- Coinsurance amounts paid for Value Tier or Tier 1 drugs.
- Amounts exceeding the allowed amount (see page 102) paid to non-network pharmacies.*
- Costs for medical services, including drugs covered under the medical benefit.
- Costs for drugs not covered by the plan (see page 42).

**Non-network pharmacies may charge more than the plan's allowed amount; you are responsible for paying this amount in addition to your coinsurance and any remaining deductible.*

What You Pay for Prescription Drugs

You may get up to a 90-day supply for most drugs, except for specialty drugs; see pages 37–38.

Tier	All Network Pharmacies *(Retail and Mail-Order)*	Prescription Cost-Limit Per 30-Day Supply *(Network Pharmacies Only)*
Value Tier	5% coinsurance *No deductible*	$10
Tier 1 Select Generic Drugs	10% coinsurance *No deductible*	$25
Tier 2 Preferred Drugs	30% coinsurance *Deductible applies*	$75
Tier 3* Nonpreferred Drugs	50% coinsurance *Deductible applies*	Specialty drugs** **only**: $150 No limit for non-specialty drugs

**Tier 3 drugs that have a generic equivalent are subject to an ancillary charge. See "Ancillary Charge: You May Pay More for Tier 3 Drugs With a Generic Equivalent" on page 34. Ancillary charges do not count toward your prescription drug deductible.*

***Specialty drugs must be purchased through the plan's network specialty pharmacy, Bioscrip; see pages 37–38.*

Ancillary Charge: You May Pay More for Tier 3 Drugs With a Generic Equivalent

The ancillary charge applies to Tier 3 nonpreferred drugs that have a generic equivalent (see definition on page 105). The plan pays as if you had purchased the Tier 1 generic drug and you pay the rest of the cost. Specifically, you pay the Tier 1 coinsurance ***plus*** the difference in cost between the generic and the brand-name drugs. **Note:** This policy is not subject to exceptions.

Ancillary charge amounts are considered noncovered and do not apply toward your prescription drug deductible or medical out-of-pocket limit.

To find out if a Tier 3 drug has a generic equivalent, check the *UMP Preferred Drug List* at **www.ump.hca.wa.gov** or call 1-888-361-1611.

ALERT! You pay the Tier 3 coinsurance and any applicable ancillary charge no matter why you take that drug, even if you cannot use the available alternatives.

If You Have Other Medical Coverage

If you have primary medical coverage through another plan that covers prescription drugs, some of the limits and restrictions to prescription drug coverage listed on pages 37–40 will apply when UMP Classic pays secondary to another plan. See "Submitting a Claim for Prescription Drugs" beginning on page 64 for how to submit your prescription drug claim.

Using Network Pharmacies When UMP Classic Is Your Secondary Coverage

If you have primary coverage through another plan that covers prescription drugs, show both plan cards to the pharmacy and make sure they know which plan is primary. It is important that the pharmacy bills the plans in the correct order, or claims may be denied or paid incorrectly.

Using Mail-Order Pharmacies When UMP Classic Is Secondary

See the Tip on page 61 on using the plan's network mail-order pharmacies when Medicare is your primary coverage.

If your primary plan uses one of this plan's network mail-order pharmacies (PPS or BioScrip), the pharmacy can process payments for both plans and charge you only what's left. Make sure that the mail-order pharmacy has your information for both plans and knows which plan is primary.

However, if your primary plan uses a different mail-order pharmacy, you will have to use your primary plan's mail order, then submit a paper claim for payment by UMP Classic; see "Submitting a Claim for Prescription Drugs" beginning on page 64 for how to do this. In this case, if you send your prescription to PPS or BioScrip, your prescription will be returned to you unfilled.

Where to Purchase Your Prescription Drugs

Retail Pharmacies

If you are retired and enrolled in Medicare, please see page 61 for more information on pharmacies.

Washington State Rx Services has a large network of retail pharmacies, which includes many pharmacies in Washington State as well as national chains. To see if your pharmacy is in the network, check the online pharmacy locator at **www.ump.hca.wa.gov** or call 1-888-361-1611.

You can use any pharmacy, but you will save money if you use a network pharmacy. When you get your prescriptions at a network pharmacy, the pharmacy sends the claim to the plan for you, and you pay only your cost-share (coinsurance, prescription drug deductible, and ancillary charge when applicable).

Mail-Order Pharmacies

ALERT! The network mail-order pharmacies cannot ship outside of the United States. See "Travel Overrides for Prescription Drugs" on page 40 if you will be traveling outside the country.

You can use either of the following network mail-order pharmacies:

- PPS (Postal Prescription Services)
- BioScrip

You may contact a network mail-order pharmacy directly (see the list on page 43), or call Washington State Rx Services at 1-888-361-1611 for information about mail-order pharmacies.

Refills can be ordered through your online pharmacy account at **www.ump.hca.wa.gov**, or by calling the network mail-order pharmacy directly; see page 43 for contact information.

Prescriptions are usually delivered within 7 to 10 days after the pharmacy receives your prescription.

When using one of the network mail-order pharmacies, the same prescription drug deductible, coinsurance, preauthorization requirements, and limits on coverage apply as for prescription drugs purchased at retail network pharmacies.

ALERT! If there is a shortage of a specific drug that a network mail-order pharmacy cannot control and it doesn't have the quantity you ordered, the pharmacy will contact you to discuss your options for obtaining your prescription(s).

Prescriptions mailed or orders placed in December but not filled until January 1 or after will be subject to the prescription drug deductible applicable on the date the prescription is processed. Because of increased volume at the end of the year, prescriptions submitted to a mail-order pharmacy in December may not be processed during the current benefit year.

Faxing Prescriptions to a Network Mail-Order Pharmacy

Prescriptions faxed to a network mail-order pharmacy must:

- Be faxed from the ***provider's*** office fax machine.
- Be on the provider's letterhead.
- Include the patient's name, address, phone number, plan ID number, and date of birth.

Remember, ***only*** a provider can fax in a prescription. The fax numbers are listed on page 43. Not following these instructions may cause a delay in filling your prescription.

ALERT! Some durable medical equipment items are not available through the plan's network mail-order pharmacies; you will need to get them through a network retail pharmacy or network durable medical equipment provider.

Use Network Pharmacies and Show Your ID Card to Get the Plan Discount

The plan pays for prescription drugs based on the allowed amount (Washington State Rx Services' standard reimbursement, unless other contractual arrangements or terms apply). If you use a non-network pharmacy or do not show your ID card at a network pharmacy, and the amount charged is more than the allowed amount, you will pay the difference in addition to your coinsurance.

Non-Network Pharmacies — Retail or Mail-Order

ALERT! The plan does not cover prescription drugs ordered through foreign (non-U.S.) mail-order pharmacies.

You can purchase your prescriptions at a non-network pharmacy, but you'll pay more if you do. If you get your prescriptions filled at a non-network pharmacy, whether a retail, internet, or mail-order pharmacy (other than the network mail-order pharmacies listed on page 43), the following applies:

- You will need to pay upfront for your prescriptions and submit a claim to Washington State Rx Services for reimbursement (see "Submitting a Claim for Prescription Drugs" starting on page 64).
- The plan pays based on the discounted amount Washington State Rx Services normally pays for the drug (allowed amount) and the drug's tier in the *UMP Preferred Drug List*. If the non-network pharmacy charges more than the allowed amount, you will pay the difference, plus your coinsurance.
- The plan pays for prescription drugs covered by the plan, whether from a network or non-network pharmacy, under the coinsurance percentages as shown in the table on page 33.
- The prescription cost-limit (see table on page 33) does not apply to prescriptions filled at non-network pharmacies.
- Non-network pharmacies will not know if a drug must be preauthorized, has a quantity limit, or has other coverage limits. If you purchase a drug from a non-network pharmacy and limits apply, the plan may not pay anything for the drug, or may pay only part of the claim.
- Unless noted on the *UMP Preferred Drug List*, specialty drugs purchased anywhere but through the plan's network specialty drug pharmacy are not covered (see "Specialty Drugs" on pages 37–38).

TIP: To submit claims for prescriptions purchased from non-network pharmacies (U.S. retail or mail-order pharmacies, or foreign retail pharmacies), see "Submitting a Claim for Prescription Drugs" on page 64.

Drugs Purchased Outside the U.S.

If you purchase drugs outside the U.S. (including Canada and Mexico) for any reason, the following rules apply:

- If you get a drug that is available by prescription only in the U.S. but obtainable outside the U.S. without a prescription, the plan will cover the drug only if the drug was prescribed by a provider prescribing within his/her scope of practice.
- If you get a drug that is approved for use in another country but not in the U.S., the plan does not cover it.
- If you get a drug that is available over-the-counter in the U.S., the plan will not cover the drug, even if you have a prescription from a provider prescribing within his/her scope of practice. The plan does not cover over-the-counter drugs.
- If you get a drug that is listed as not covered in the *UMP Preferred Drug List*, the plan will not cover the drug.

To submit a claim for a prescription drug purchased outside the U.S., see "Submitting a Claim for Prescription Drugs" beginning on page 64. All necessary information must be included on the prescription drug claim form and translated into English, with drugs and dosage documented, along with the currency exchange rate. The plan does not pay for that translation and documentation.

ALERT! The plan does not cover prescription drugs purchased through foreign (outside the U.S.) mail-order pharmacies.

Limits on Your Prescription Drug Coverage

The plan may exclude, discontinue, or limit coverage for any drug or shift a drug to a different tier for any of the following reasons:

- New drugs are developed.
- Generic drugs become available.
- There is a sound medical reason.
- There is lack of scientific evidence a drug works as well and is as safe as existing drugs used to treat the same or similar conditions.
- One of the following recommends a change: The Washington State Pharmacy & Therapeutics (P&T) Committee, or a P&T Committee of a Washington State Rx Services partner (see list on page 31).
- The Washington State Health Technology Clinical Committee requires such a change.
- A drug receives FDA approval for a new use.

Programs Limiting Drug Coverage

The limits and restrictions described from "Limits on Your Prescription Drug Coverage" on this page through "Refill Too Soon" on page 40 help us monitor drug usage, safety, and costs. Drugs may be added to any of these programs at any time. You can find out if your drug falls under any of these limits and restrictions by checking the *UMP Preferred Drug List* (PDL) or calling Washington State Rx Services at 1-888-361-1611.

Preauthorization

Some medications require preauthorization, or the plan will not cover them. You can find out if your drug requires preauthorization by calling Washington State Rx Services, or checking the *UMP Preferred Drug List* at **www.ump.hca.wa.gov**.

If your drug requires preauthorization, your pharmacist or prescribing provider must call Washington State Rx Services at 1-888-361-1611 to request it. **NOTE:** Drugs covered under the medical benefit rather than the prescription drug benefit have different rules for preauthorization; call Customer Service at 1-888-849-3681 for more information.

ALERT! Authorization of drug coverage determines only that the plan will cover the drug and does not change the drug's tier. You still pay according to the drug's tier as designated in the *UMP Preferred Drug List*.

Quantity Limits

The plan limits the quantities you can purchase per prescription for certain drugs. To request preauthorization for quantities exceeding the limit for a drug, your pharmacist or prescribing provider must call Washington State Rx Services at 1-888-361-1611.

If the plan denies your request or your provider or pharmacist does not get preauthorization, we will cover the drug only up to the quantity limit amount. You will pay for any extra amount.

Specialty Drugs

ALERT! BioScrip, the plan's network specialty pharmacy, is unable to ship outside the United States. See "Travel Overrides for Prescription Drugs" on page 40 if you will be traveling outside the country.

"Specialty" drugs are high-cost injectable, infused, oral, or inhaled drugs that generally require special handling (including a few products, such as intrauterine devices [IUDs]). Specialty drugs are subject to special rules. You can find out if a drug is a specialty drug by checking the *UMP Preferred Drug List* at **www.ump.hca.wa.gov**, or by calling

Washington State Rx Services. Specialty drugs are covered under the cost-share tier listed on the *UMP Preferred Drug List*. If your Tier 3 specialty drug has a generic equivalent, you will also have to pay the ancillary charge (see page 34).

You may receive ***up to*** a 30-day supply for specialty medications per prescription or refill. Specialty drugs are covered only when purchased through the plan's network specialty drug pharmacy. Order your specialty medications from BioScrip by calling 1-877-316-8921 (24 hours a day, 7 days a week, including holidays). However, orders received after 1 p.m. Pacific Time will not be filled until the next business day.

Specialty drugs require preauthorization. A Patient Care Coordinator will contact your provider to review the coverage criteria and authorize the prescription if the criteria are met. The Patient Care Coordinator will work with you to schedule a delivery time for the medication. If you are unable to be present for the delivery, the specialty pharmacy will deliver your medications anywhere you choose, such as to your workplace or to a neighbor, but not out of the country. Specialty medications often require special handling and storage, so someone must be present to sign for them.

If your provider will be administering a medication, you can have it shipped to the provider's office. Please note that UMP Classic and the specialty pharmacy are not responsible once the drugs are received at the provider's office.

TIP: For your convenience, the specialty pharmacy can provide your non-specialty drugs in addition to specialty drugs. A non-specialty drug will be covered according to its tier on the *UMP Preferred Drug List*.

Prescription Cost-Limit for Specialty Drugs

Some specialty medications are available only in packages with more than a 30-day supply. In this case, the standard prescription cost-limit per 30-day supply listed in the table on page 33 will be multiplied by the following to determine your cost limit:

- Up to a 30-day supply, multiply by 1 (same as the standard prescription cost-limit).
- A 31- to 60-day supply, multiply by 2.
- A 61-day and greater supply, multiply by 3.

Example: If your specialty drug is Tier 3 and is only supplied in packages containing a 45-day supply, your cost-limit would be $300 ($150 x 2).

Step Therapy

When a drug is part of the step therapy program, you have to try certain drugs (Step 1) before the prescribed Step 2 drug will be covered. When a prescription for a step therapy drug is submitted "out of order," meaning you haven't first tried the Step 1 drug before submitting a prescription for a Step 2 drug, your prescription will not be covered. When this happens, your provider will need to prescribe the Step 1 drug for you.

If you or your provider feels that you need the Step 2 prescription filled as originally written, your pharmacist or prescribing provider can call Washington State Rx Services at 1-888-361-1611 and request coverage. You will have to pay the entire cost of the drug if you have not tried the Step 1 drug and coverage hasn't been authorized before you get the Step 2 drug.

To find out if step therapy applies to your drug, check the *UMP Preferred Drug List* at **www.ump.hca.wa.gov,** or call Washington State Rx Services at 1-888-361-1611.

Note: Only network pharmacies will check to see if step therapy applies to your prescription

drug. If you get a step therapy drug at a non-network pharmacy, the drug may not be covered.

ALERT! If a Step 2 or Step 3 drug is approved for coverage by Washington State Rx Services, you will pay the applicable cost-share of that drug according to its tier in the *UMP Preferred Drug List*, including the ancillary charge if it applies.

Can the Pharmacist Substitute One Drug for Another?

Generic Substitution Under Washington State Law

When a brand-name drug has a generic equivalent (see definition on page 105), pharmacists in Washington State must substitute the generic equivalent drug for the brand-name drug. Your provider may write the prescription "dispense as written" if he or she wants you to get only the brand-name drug, or you can tell the pharmacist you want the brand-name drug. However, you will pay more for drugs that have a generic equivalent.

ALERT! New generic drugs are released throughout the year. If you want to take advantage of the cost-savings that generics provide, ask your provider to allow substitution on your prescriptions, even if a generic drug isn't available. That way, when one becomes available, the pharmacist can automatically refill with the generic.

Therapeutic Interchange Program (TIP)

The Therapeutic Interchange Program (TIP) allows a pharmacist to substitute a "therapeutic alternative" drug for a ***nonpreferred brand-name drug*** (Tier 3) in certain cases. Therapeutic alternatives are drugs that are chemically different from your prescribed drug but provide the same therapeutic benefit.

You can find out if your drug is affected by TIP by checking the *UMP Preferred Drug List* at **www.ump.hca.wa.gov** or by calling Washington State Rx Services at 1-888-361-1611. Not all nonpreferred drugs are affected by TIP.

The pharmacist will substitute the preferred drug when your prescribing provider has "endorsed" the Washington Preferred Drug List, and:

- You are filling your prescription in Washington State or through one of the network mail-order pharmacies.
- Your prescribing provider allows substitution on your prescription.

If you do not want your drug to be changed, simply ask the pharmacist to fill the prescription as written.

Regardless of whether you or your prescriber ask the pharmacist to "dispense as written," if you get the nonpreferred drug, you will pay the higher Tier 3 coinsurance. If the nonpreferred drug has a generic equivalent, you will also pay an ancillary charge.

How Does TIP Work at a Network Mail-Order Pharmacy?

The pharmacy will contact your provider to request authorization for the substitution. If approved by the provider, you will receive the alternative preferred drug along with a letter of explanation. If the pharmacy cannot get an authorization from your provider within 48 hours, the prescription will be filled as written, and you will be charged the Tier 3 coinsurance.

Travel Overrides for Prescription Drugs

You may request a travel override to get an additional supply of medications for extended business or vacation travel, only when you will be outside the United States. All of the conditions listed below apply.

- The plan will allow up to two travel overrides per calendar year, not to exceed a year's supply.
- Travel overrides will be granted only while you are covered by the plan. If your eligibility is ending, the plan does not cover drugs past the time when your enrollment in the plan ends.
- You may request up to the amount of medication you will need during your travel period for as many covered drugs as you want to request.
- You will pay applicable charges (deductible, coinsurance, or ancillary charges) for each extra supply received.

To request a travel override, call Washington State Rx Services at 1-888-361-1611.

Refill Too Soon

The plan will not cover a refill until 84% of the prior prescription should be used up. Claims for therapeutic equivalents of the previously prescribed drug will also be denied. This also applies if your prescription is destroyed, lost, or stolen. For example, if you get a 90-day supply and you try to refill this prescription before 76 days have passed, coverage will be denied.

What Can I Do If Coverage Is Denied?

TIP: If your prescription claims are denied by the pharmacy due to eligibility issues or termination of coverage, contact:

- **Employees** — Your employer's personnel, payroll, or benefits office.
- **All other members** — PEBB Benefits Services at 1-800-200-1004.

If a network pharmacy (including a mail-order or specialty pharmacy) tells you that preauthorization is required, your pharmacist or prescribing physician may contact Washington State Rx Services at 1-888-361-1611 to request a coverage review.

If Washington State Rx Services denies the coverage request, or if a network pharmacy tells you that coverage is denied, quantities are limited, or the prescription is otherwise not covered in full, you have the right to submit an appeal. (See instructions for appealing on pages 69–74.)

If your provider thinks that you need the medication immediately, he or she may request an expedited review. This means that the decision whether to cover the medication will be made within 72 hours of the request. In this case, you may choose to purchase a three-day supply at your own expense. You will receive a written notice from Washington State Rx Services of the decision. We will reimburse you according to the drug's tier on the *UMP Preferred Drug List* only if Washington State Rx Services approves coverage of the drug.

Guidelines for Drugs Covered

To be covered, a prescription drug must meet all of the following criteria:

- Can be legally obtained in the United States only with a written prescription.
- Is approved by the Food and Drug Administration (FDA).
- Does ***not*** have an over-the-counter alternative with similar safety, efficacy, and ingredients. (See exceptions below.)
- Is not classified as a vitamin (except as listed below), mineral, dietary supplement, homeopathic drug, or medical food.
- Has been reviewed by one of the following: the Washington State Pharmacy & Therapeutics (P&T) Committee or a P&T Committee of a Washington State Rx Services partner (see list on page 31).

ALERT! Only generic prenatal vitamins and generic fluoride supplements are covered; brand-name prenatal vitamins and fluoride supplements are not covered.

The plan covers the following prescription drugs as **exceptions** to the above rules:

- Activated vitamin D for patients on renal dialysis or with parathyroidism.
- Select generic fluoride supplements for prevention of dental caries for children ages 6 months to 18 years.
- Select generic prescription prenatal vitamins for women of childbearing age.

Your pharmacy benefit also includes the following nonprescription drugs and supplies:

- Insulin and diabetic supplies such as blood glucometers, test strips, lancets, and insulin syringes used in the treatment of diabetes. (See "Diabetes Care Supplies" on page 18 for more information).
- Select contraceptive devices and drugs (see page 20).
- Select generic over-the-counter prenatal vitamins for women of childbearing age.
- Other over-the-counter products that are specifically noted in the *UMP Preferred Drug List* as covered under Tier 1, Tier 2 or Tier 3.

To be covered, the above-listed prescription and non-prescription drugs and supplies must:

- Be prescribed by a provider prescribing within his/her scope of practice (is licensed to prescribe).
- Be dispensed from a licensed pharmacy employing licensed registered pharmacists.
- Meet plan coverage criteria.

The plan covers FDA-approved drugs used for off-label indications (that is, prescribed for a use other than its FDA-approved label) only if recognized as effective for treatment:

- In a standard reference compendium (defined on page 114).
- In most relevant peer-reviewed medical literature (defined on page 111), if not recognized in a standard reference compendium.
- By the federal Secretary of Health and Human Services.

The plan will not cover any drug when the FDA has determined its use to be unsafe.

ALERT! Drugs newly approved by the FDA must be reviewed by the Pharmacy & Therapeutics Committee before UMP Classic will cover the drug. If you are prescribed a new drug, call Washington State Rx Services to ask about coverage.

Products Covered Under the Preventive Care Benefit

A few products are covered under the preventive care benefit, if recommended by the U.S. Preventive Services Task Force (USPSTF) as described on pages 26–27, and must conform to coverage guidelines stated above. The brand and type of products covered are limited; call 1-888-361-1611 for more information on which ones are covered. These products must be purchased from a network pharmacy; non-network or paper claims will not be reimbursed.

Some Injectable Drugs Are Covered Only Under the Prescription Drug Benefit

The following drug classes are covered only under the prescription drug benefit:

- Growth hormones
- Self-administered drugs for multiple sclerosis
- Self-administered drugs for rheumatoid arthritis

A drug may be approved for use for another condition, but is still available only through the prescription drug benefit.

ALERT! If a claim for one of these drugs is submitted as medical, it will be denied.

Compounded Prescription Drugs

Compounded prescription drugs are the result of combining, mixing, or altering of ingredients by a pharmacist in response to a physician's prescription to create a new drug tailored to the specialized medical needs of an individual patient. Traditional compounding typically occurs when an FDA-approved drug is unavailable or a licensed health care provider decides that an FDA-approved drug is not appropriate for a patient's medical needs. Compounded prescription drugs are covered under Tier 3. NOTE: Additional documentation must be sent along with member-submitted claims.

Guidelines for Drugs Not Covered

Drugs not covered under the plan include but are not limited to:

- Experimental or investigational drugs.
- Dietary supplements, vitamins, minerals, herbal supplements, and medical foods.
- Homeopathic drugs, including FDA-approved prescription products.
- Dental preparations, such as rinses and pastes.
- Over-the-counter drugs or prescription drugs that have an over-the-counter equivalent, except for the drugs specified under "Guidelines for Drugs Covered" on page 41. NOTE: Prescription drugs with over-the-counter alternatives having similar safety, efficacy, and ingredients are not covered.
- Drug costs covered by other insurance including Medicare Part B (see page 61 regarding coordination of benefits with Medicare Part B, and pages 55–56 for coordination with other plans).
- Prescription drugs for tobacco cessation, except as authorized by *Quit for Life* counselors for participants in that program (see page 29).

The plan also does not cover drugs to treat conditions that are not covered under the medical benefit. These include, but aren't limited to, drugs for:

- Cosmetic purposes
- Infertility
- Obesity (or weight loss)
- Sexual dysfunction

Prescription Drug Contacts

Washington State Rx Services	1-888-361-1611 7:30 a.m. to 5:30 p.m. Pacific Time, Monday–Friday
Network Mail-Order Pharmacies ***Faxing prescriptions*** *(see page 35)* *Note: Only a provider can fax a prescription.*	
◆ PPS (Postal Prescription Services)	1-800-552-6694 Fax 1-800-723-9023 (providers only)
◆ BioScrip Mail Order	1-877-316-8921 Fax 1-877-517-9302 (providers only)
Mailing a prescription order Postal Prescription Services PO Box 2718 Portland OR 97208-2718 BioScrip Pharmacy PO Box 1778 Columbus OH 43216	Contact the mail-order pharmacy for instructions
Specialty Pharmacy (BioScrip) (see pages 37–38)	1-877-316-8921 Fax 1-866-488-5809 (providers only)
To request preauthorization (providers)	1-888-361-1611 Fax 1-800-207-8235
Submit paper claims Find claim forms at **www.ump.hca.wa.gov**	Washington State Rx Services Attn: Pharmacy Claims PO Box 40168 Portland, OR 97240-0168
Send appeals/complaints	Washington State Rx Services Attn: Appeals PO Box 40168 Portland, OR 97240-0168 Fax 1-866-923-0412
Online services ◆ Find a network pharmacy ◆ Find a network vaccination pharmacy ◆ Refill mail-order prescriptions ◆ Get estimates of drug costs at retail versus mail order	**www.ump.hca.wa.gov**

Limits on Plan Coverage

Preauthorization

Some medical services and supplies require authorization from UMP Classic to determine whether the service or supply meets the plan's medical necessity criteria, whether the service or supply has been accurately billed, and whether the charge is appropriate. (The fact that a service or supply is prescribed or furnished by a provider does not, by itself, make it medically necessary; see definition on pages 108–109). Decisions by the Health Technology Clinical Committee may affect coverage for services; see page 14 for more information.

Which Services Require Preauthorization?

ALERT! The list of services requiring preauthorization may change during the year, usually due to new procedures or devices, or newly identified safety concerns. If your service doesn't appear in the list below, you may call Customer Service at 1-888-849-3681 to ask if it requires preauthorization.

You must receive preauthorization from the plan for the following services. If you don't, the service may not be covered. To ensure you receive the maximum benefit, call 1-888-849-3681 for preauthorization before receiving these services. Your provider may fax preauthorization requests to 1-877-663-7526. Also see "Notification for Facility Admissions" on page 45.

- Artificial hearts, total.
- Artificial intervertebral disc surgery.
- Bariatric surgery (see page 15).
- Biofeedback (only for headaches per coverage criteria).
- Bone growth (osteogenic) stimulators.
- Cardioverter device, wearable.
- Certain injectable drugs when obtained through a retail pharmacy or a network mail-order pharmacy; see page 42. (These drugs are indicated on the *UMP Preferred Drug List*.)
- Chemical dependency treatment in residential treatment facilities.
- Computed Tomographic Angiography (CTA).
- Continuous glucose monitors.
- **Cosmetic services:** Services that may restore or improve appearance, but may also correct a functional impairment.
- Discography.
- Drugs covered under the medical benefit may require preauthorization; see our policies at **www.ump.hca.wa.gov**.
- **Experimental or investigational services:** Services that are considered experimental or investigational, but may be medically necessary for certain diagnoses.
- Hip resurfacing.
- Hyperbaric oxygen therapy.
- Implantable infusion pumps.
- Intensity modulated radiation therapy (IMRT).
- Knee arthroplasty, total.
- Long-term acute care (LTAC) facility admissions.
- Mental health treatment in residential treatment facilities.
- Obstructive Sleep Apnea Surgery.
- Oscillatory chest compression devices.

- Skilled nursing facility admissions.
- Spinal (lumbar) fusion surgery.
- Stents, drug coated or drug-eluting (DES).
- Temporomandibular joint (TMJ) surgery.
- Transplants (except for cornea and kidney).
- Vagal nerve stimulation.
- Varicose veins treatment.
- Ventricular assist devices.
- Wheelchairs.

See the sections "Summary of Benefits" (pages 8–13), "Benefits: What the Plan Covers" (pages 14–30) and "What the Plan Doesn't Cover" (pages 47–51) for more information on all services and supplies that require preauthorization.

What Is the Difference Between Preauthorization and Notification?

"Preauthorization" is when your provider sends a request for coverage of one of the services on the list above, and the plan sends either an approval or denial of coverage. If services that require preauthorization are not approved before being provided, coverage may be denied. "Notification" applies to the list of services below, and means that your provider must contact the plan to let us know when you receive services.

Notification for Facility Admissions

Your provider must notify the plan when you receive any of the following services:

- Chemical dependency treatment:
  - Detoxification
  - Inpatient services (all overnight stays in hospitals or other facilities)
  - Intensive outpatient services
  - Partial hospitalization
- Inpatient hospital admissions
- Inpatient physical, speech, occupational, or neurodevelopmental therapy admissions
- Mental health services:
  - Inpatient services (overnight stays in hospitals or other facilities)
  - Partial hospitalization

Call Customer Service to Find Out If Services Are Covered

For services not requiring preauthorization, you may call Customer Service to ask if a particular service is generally covered by the plan. However, until a provider sends a claim for services to the plan, we are unable to provide an accurate estimate of payment.

Why Can't the Plan Tell Me How Much I'll Pay Before I Receive Services?

When a provider bills for a service, the plan pays for it based on procedure codes developed by independent organizations (not affiliated with the plan). Each code describes a particular service in some detail, and there are many codes for similar-sounding services. Your provider, not the plan, determines which of these codes is used. If you're receiving covered services from a network provider, you'll generally pay 15% of the allowed amount per code billed until you reach your medical out-of-pocket limit (see page 7). Once you reach that limit, the plan pays 100% of the allowed amount for covered services from network providers.

Case Management

Case Management for Complex Health Care Needs

Case management is a free service offered by the plan to help enrollees with serious, complex, or difficult health care needs coordinate their care. You work with a nurse case manager who assists you in finding health care providers and services appropriate for your treatment. When preauthorization is requested for a condition that may benefit from case management services or the plan receives a claim for services indicating complex health needs, you will be contacted by case management staff to discuss your options.

This free service helps you:

- Ensure you get the most out of your UMP Classic benefits.
- Find network providers, facilities, and other resources to assist in the coordination of your medical care.
- Keep your health care costs down (for example, negotiating rates when no network providers are available).

You, your family, or any provider or facility (such as a hospital) involved in your treatment may call 1-866-543-5765 to request case management services.

Case Management as a Condition of Coverage

The plan medical director may review medical records and determine that your use of certain services is potentially harmful, excessive, or medically inappropriate. Based on this determination, the plan may require you to participate in and comply with a case management plan as a condition of continued benefit payment. Case management may include designating a primary physician (MD or DO) to coordinate care, and designating a single hospital and pharmacy to provide covered services or medications. The plan may deny payment for any services received outside of the required case management plan, except medically necessary emergency services.

What the Plan Doesn't Cover

Expenses Not Covered, Exclusions, and Limitations

This plan covers only the services and conditions specifically identified in this *Certificate of Coverage*. Unless a service or condition fits into one of the specific benefit definitions, it is not covered. If you have questions, call Customer Service at 1-888-849-3681.

Here are some examples of common services and conditions that are not covered. Many others are also not covered—these are examples only, not a complete list. These examples are called exclusions, meaning these services are **not** covered, ***even if medically necessary.***

1. Air ambulance, if ground ambulance would serve the same purpose.
2. Ancillary charge: The difference between the cost of a brand-name drug and its generic equivalent (see page 34 for definition of ancillary charge).
3. Arthroscopic knee surgery for the diagnosis of osteoarthritis.
4. Bariatric surgery follow-up care, including lap band fills, if surgery was not covered under a PEBB plan.
5. Breast pumps.
6. Cardiac Artery Calcium Scoring.
7. Circumcision.
8. Complications of bariatric surgery, no matter when the complications occur, if the bariatric surgery was not paid for by a PEBB plan (even if the surgery would be covered during the current plan year).
9. Complications arising directly from services that would not be covered by the plan during the current plan year. The plan will, however, cover complications arising directly from services that the plan paid for you in the past.
10. Cosmetic services or supplies, including drugs and pharmaceuticals. However, the plan does cover:
    - Reconstructive breast surgery following a mastectomy necessitated by disease, illness, or injury.
    - Reconstructive surgery of a congenital anomaly, such as cleft lip or palate, to improve or restore function.
11. Court-ordered care, unless determined by the plan to be medically necessary and otherwise covered.
12. Custodial care (see definition on page 103).
13. Dental care for the treatment of problems with teeth or gums, other than the specific covered dental services listed on page 17.
14. Dietary or food supplements, including but not limited to:
    - Herbal supplements, dietary supplements, medical foods, and homeopathic drugs.
    - Infant or adult dietary formulas (except for limited products for the treatment of congenital metabolic disorders such as phenylketonuria [PKU] detected by newborn screening when specialized formulas are medically necessary).
    - Medical foods.
    - Minerals.
    - Prescription or over-the-counter vitamins (see exceptions on page 41).

15. Dietary programs.
16. Drugs or medicines not covered by the plan as described in the "Your Prescription Drug Benefit" section, pages 31–43.
17. Drugs or medicines obtained through foreign (non-United States) mail-order pharmacies.
18. Educational programs, except as described under "Diabetes Education" on page 18 or "Tobacco Cessation Program" on page 29.
19. Email consultations or e-visits.
20. Equipment not primarily intended to improve a medical condition or injury, including but not limited to:
    - Air conditioners or air purifying systems
    - Arch supports
    - Communication aids
    - Elevators
    - Exercise equipment
    - Massage devices
    - Overbed tables
    - Sanitary supplies
    - Telephone alert systems
    - Vision aids
    - Whirlpools, portable whirlpool pumps, or sauna baths
21. Erectile or sexual dysfunction treatment with drugs or pharmaceuticals.
22. Experimental or investigational services, supplies, or drugs.
23. Eye surgery to alter the refractive character of the cornea, such as radial keratotomy, photokeratectomy, or LASIK surgery.
24. Foot care: Cutting of toenails; treatment for diagnosed corns and calluses; or any other maintenance-related foot care.
25. Hip surgery for treatment of Femoroacetabular Impingement Syndrome (FAI).
26. Home health care, except as described on page 21. The plan does not cover the following services:
    - Custodial care.
    - Maintenance care.
    - Private duty or continuous care in the member's home.
    - Housekeeping or meal services.
    - Care in any nursing home or convalescent facility.
    - Care provided by or for a member of the patient's family.
    - Any other services provided in the home that do not meet the definition of skilled home health care as described on page 21 or not specifically listed as covered in this Certificate of Coverage.
27. Hospital inpatient charges such as:
    - Admissions solely for diagnostic procedures that could be performed on an outpatient basis.
    - Reserved beds.
    - Services and devices that are not medically necessary (see definition of "Medically Necessary Services, Supplies, Drugs, or Interventions" on pages 108–109).
    - Personal or convenience items.
    - Private room charges.
28. Hyaluronic acid injections (viscosupplementation) for treatment of pain in any joint other than the knee.
29. Immunizations, except as described on page 27.
30. Immunizations for the purpose of travel or employment, even if recommended by the Centers for Disease Control and Prevention.
31. In vitro fertilization and all related services and supplies, including all procedures involving selection of embryo for implantation.

32. Infertility or fertility testing or treatment, including drugs, pharmaceuticals, artificial insemination, and any other type of testing, treatment, complications resulting from such treatment (for example, selective fetal reduction), or visits for infertility.
33. Learning disabilities treatment after diagnosis, with two exceptions: as described under "Physical, Occupational, Speech, and Neurodevelopmental Therapy" on page 26 or when part of treating a mental health disorder as described on page 24.
34. Magnetic Resonance Imaging—Upright MRIs (uMRI), also known as "positional," "weight-bearing" (partial or full), or "axial loading."
35. Maintenance therapy.
36. Manipulations of the spine or extremities, except as described under "Spinal and Extremity Manipulations" on page 28.
37. Marriage, family, or other counseling or training services, except as provided to treat an individual member's neuropsychiatric, mental, or personality disorder.
38. Massage therapy services longer than one hour per session.
39. Massage therapy services when the massage therapist is not a network provider.
40. Medicare-covered services or supplies delivered under a private contract with a provider who does not offer services through Medicare, when Medicare is the patient's primary coverage (see page 60).
41. Missed appointment charges.
42. Noncovered provider types: Services delivered by providers not listed as a covered provider type (see page 4).
43. Non-network provider charges that are above the allowed amount.
44. Orthognathic surgery (see definition on page 111).
45. Orthoptic therapy except for the diagnosis of strabismus, a muscle disorder of the eye.
46. Orthotics: Items such as shoe inserts and other shoe modifications are not covered.
47. Panniculectomy or removal of excess skin for any reason.
48. Prescription drug charges over the allowed amount, regardless of where purchased.
49. Prescription drugs that require preauthorization unless the request is:
    - Supported by medical justification from a clinician other than the patient or member of the patient's family.
    - Approved by the plan.
50. Provider administrative fees—Any charges for completing forms, copying records, or finance charges, except for records requested by the plan to perform retrospective (postpayment) review.
51. Recreation therapy.
52. Replacement of lost, stolen, or damaged durable medical equipment.
53. Replacement of medications that are any of the following:
    - Confiscated or seized by Customs or other authorities
    - Contaminated
    - Damaged
    - Lost or stolen
    - Ruined
54. Residential treatment programs that are not solely for chemical dependency treatment or a mental health condition requiring inpatient treatment. Examples include, but are not limited to, schools, wilderness programs, and behavioral programs.
55. Reversal of voluntary sterilization (vasectomy, tubal ligation, or similar procedures).
56. Separate charges for records or reports.

57. Service animals: Any expenses related to a service animal.

58. Services covered by other insurance, including but not limited to motor vehicle, homeowner's, renter's, commercial premises, personal injury protection (PIP), automobile no-fault, underinsured or uninsured motorist coverage. You are responsible for any cost-sharing required under the other coverage as allowed by state law. See page 77 for more about how this works.

59. Services delivered by providers delivering services outside the scope of their licenses.

60. Services or supplies:
    - That are not medically necessary for the diagnosis and treatment of injury or illness or restoration of physiological functions, and are not covered as preventive care. This applies even if services are prescribed, recommended, or approved by your provider.
    - For which no charge is made, or for which a charge would not have been made if you had no health care coverage.
    - Provided by a family member or any household member.
    - Provided by a resident physician or intern acting in that capacity.
    - That are solely for comfort.
    - For which you are not obligated to pay.

61. Services performed during a noncovered service.

62. Services performed only to ensure the success of a noncovered service, including but not limited to a hiatal hernia repair done to ensure the success of a noncovered Laparoscopic Adjustable Gastric Banding surgery.

63. Services, supplies, drugs, treatments, or devices determined not to be covered by the state Health Technology Clinical Committee.

64. Services, supplies, or drugs related to occupational injury or illness (see definition on page 110).

65. Services, supplies, or items that require preauthorization unless the request is:
    - Supported by medical justification from a clinician other than the patient or member of the patient's family.
    - Approved by the plan.

66. Sexual reassignment drugs, surgery, services, or supplies.

67. Skilled nursing facility services or confinement:
    - When primary use of the facility is as a place of residence.
    - When treatment is primarily custodial.

68. Spinal cord stimulator for chronic neuropathic pain.

69. Spinal injections of the following types:
    - Medial branch nerve block
    - Intradiscal
    - Facet

70. Spinal surgical procedures known as vertebroplasty, kyphoplasty, and sacroplasty.

71. Telephone consultations, except as described under "Telehealth Services" on page 29.

72. Temporomandibular joint (TMJ) disorder treatment, except as described under "Temporomandibular Joint (TMJ) Treatment" on page 29.

73. TENS (Transcutaneous Electrical Nerve Stimulation) Units.

74. Tobacco cessation services, supplies, or medications, except as described under "Tobacco Cessation Program" on page 29.

75. Travel, transportation, and lodging expenses, other than ambulance services covered by the plan.

76. Ultrasounds during pregnancy, except as described on page 25.

77. Weight control, weight loss, and obesity treatment:
    - **Non-surgical:** Any program, drugs, services, or supplies for weight control, weight loss, or obesity treatment. Exercise or diet programs (formal or informal), exercise equipment, or travel expenses associated with non-surgical or surgical services are not covered. Such treatment is not covered even if prescribed by a provider.
    - **Surgical:** Any bariatric surgery procedure, any other surgery for obesity or morbid obesity, and any related medical services, drugs, or supplies, except if approved through case management as described under "Bariatric Surgery" on page 15. Removal of excess skin and routine post-operative care following a noncovered bariatric surgery are not covered.
78. Wilderness training programs.
79. Workers' compensation: Services or supplies for work-related injury or illness are not covered, even if the service or supply is not a covered workers' compensation benefit. The only exception is if an employee or dependent is exempt from state or federal workers' compensation law.

If you have questions about whether a certain service or supply is covered, call Customer Service at 1-888-849-3681.

If You Have Other Medical Coverage

Different rules apply to retirees with Medicare; see "For Retirees Enrolled in Medicare" beginning on page 57 for how UMP Classic works with Medicare.

Coordination of Benefits

What is Coordination of Benefits?

Coordination of benefits (COB) happens when you have health coverage through two or more groups (such as your employer and your spouse's employer), and these two group health plans both pay a portion of your health care claims. The rules below determine which plan pays first ("primary payer") and which pays second ("secondary payer"). These rules are set by state and federal regulations.

TIP: If you have other health coverage, it is important that you let all of your providers know, including the pharmacies where you get your prescription drugs.

Which Plans Does UMP Classic Coordinate Benefits With?

UMP Classic coordinates benefits with these types of plans:

1. Group, blanket or franchise health or disability insurance policies, health care service contractor and health maintenance organization group agreements issued by insurers, health care service contractors, and health maintenance organizations.
2. Labor management trusteed plans, labor organization plans, employer plans, or employee benefit organization plans.
3. Governmental programs including, but not limited to, Medicare and Medicaid.

How Does Coordination of Benefits Work?

UMP Classic uses a type of coordination of benefits called nonduplication of benefits (see definition on page 110). If another plan is your primary plan (see rules below), it will process claims first and pay its normal benefit. When UMP Classic is your secondary plan, we will pay only when the primary plan benefit is less than the benefit UMP Classic would pay if it was the primary plan. If the primary plan pays as much as or more than the UMP Classic benefit, UMP Classic pays nothing.

Who Pays First?

FOR MORE INFORMATION: If you cannot determine which plan is primary, call Customer Service at 1-888-849-3681.

When UMP Classic coordinates benefits with other plans, the following rules determine which plan pays first. These rules apply in order, so the first rule below that applies to your situation will determine which plan is your primary coverage (subsequent rules do not apply).

The Following Plan Pays First

1. Any plan that does not coordinate benefits.
2. The plan that covers the patient as a subscriber, not a dependent.
3. The plan that covers the patient (or their spouse or domestic partner) as an active

employee pays before a plan that covers you as a retired employee.

4. The plan that has covered the patient (or their spouse or domestic partner) as a subscriber the longest, if there are two plans and numbers 1–3 in the list above do not determine which plan pays first.
5. The plan that covers the patient (or their spouse or domestic partner) as an active employee if the other coverage is Medicare.
6. A plan covering the patient as an employee, subscriber, retiree, or their dependent of such a patient will pay before a COBRA or a state right of continuation plan.

For Dependent Children

- If a dependent child has coverage through his or her employment, the child's coverage pays before the parent's.
- This plan is usually primary over Medicaid programs that cover children.

Dependent children of married parents

The plan of the parent whose birth month and day is earlier in the year pays first (for example, the plan of a parent born April 14 is primary over the plan of a parent born August 21). This is called the "birthday rule." This rule looks only at the month and day, not the year. If both parents have the same birthday, the plan that covered either parent longer is primary.

Exception for newborn children: Under Washington State law, the mother's health plan must cover the newborn for the first 21 days of life. Therefore, the mother's plan pays first for covered charges during the first 21 days of life. After that date, standard rules apply.

Dependent children of legally separated or divorced parents

When there is no court order that specifies which parent is responsible for providing health insurance coverage, the following standard coordination of benefits rules determine which plan pays first:

1. The plan of the custodial parent.
2. The plan of the custodial parent's spouse, if the custodial parent has remarried.
3. The plan of the non-custodial parent.
4. The plan of the non-custodial parent's spouse, if the non-custodial parent has remarried.

The custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

The ***birthday rule*** is used to determine which parent's plan pays first if:

- The court order states that both parents are responsible for the child/children's health coverage and expenses.
- The court orders joint custody without specifying that one parent is responsible for the child/children's health coverage and expenses.

If the court order states one parent is to assume primary financial responsibility for the child but does not mention responsibility for health coverage or health care expenses, the plan of the parent assuming financial responsibility is primary.

In some cases, a court order determines payment for health care expenses and ***standard coordination of benefits rules may not apply***. In these cases, you must promptly provide UMP Classic with copies of legal documents needed to decide which plan is primary and which is secondary.

For a dependent child covered under more than one plan of individuals who are not the parents or stepparents of the child (such as

grandparents or other guardians), the birthday rule will apply.

If none of the preceding rules determines who pays first, then each plan covers half of the allowed expenses.

What Happens With Federal and Military Plans?

UMP Classic usually pays primary over certain federal or military programs for veterans.

How Does UMP Classic Pay When It's Primary?

When UMP Classic is the primary payer (pays first), UMP Classic pays its normal benefit (as described in this *Certificate of Coverage*). You may need to send UMP Classic's Explanation of Benefits and a copy of your provider's bill to your secondary payer to receive payment. Check with that plan for more information.

What Happens When Medicare Is Secondary to UMP Classic?

If UMP Classic is your primary coverage and Medicare is secondary, make sure that your provider agrees to bill Medicare as secondary to get the maximum benefit from both plans. Medicare generally accepts claims only from providers, so you may not be able to send a claim to Medicare for secondary payment. The provider would need to bill Medicare after UMP Classic has processed the claim.

How Does UMP Classic Pay When It's Secondary?

If Medicare is your primary plan, see "When Do I Pay? How Billing Works" on page 60 for more information.

When UMP Classic is secondary to another group health plan, UMP Classic pays according to nonduplication of benefits rules (see definition on page 110). This means that UMP Classic pays a secondary benefit only when the primary plan's benefit is less than UMP Classic's normal benefit. UMP Classic does not pay the rest of the allowed amount.

NOTE: Ask if your provider will submit claims to both your primary and secondary plans.

Here's how it works:

- Your primary plan processes the claim and sends an explanation of benefits. You or your provider sends a copy of the claim and the primary plan's explanation of benefits to UMP Classic.
- UMP Classic reviews the primary plan's benefit calculation, and the primary plan payment, if any.
- UMP Classic determines what the normal benefit would be if it was the only plan.
- After the primary plan pays its normal benefit, UMP Classic pays toward the remaining balance, but not more than its normal benefit for the services.
- If the primary plan paid nothing, UMP Classic would pay its normal benefit and you pay your usual copay or coinsurance.

When UMP Classic pays secondary to another plan, you still have to satisfy any applicable deductible before UMP Classic pays benefits.

The total payment from both plans will not exceed the amount UMP Classic would have paid if it was the primary plan.

Please contact Customer Service at 1-888-849-3681 for help with any questions when you or a family member is covered by more than one plan.

ALERT! All health plans have deadlines for filing a claim, called a "timely filing" requirement. If a claim is not submitted within a plan's timely filing limit, the plan can deny it. If your primary plan delays payment on a claim, the claim should be submitted to the secondary plan within the timely filing limit to prevent denial of the claim. Promptly notifying your providers of any change to your coverage will help avoid errors and delays in processing of claims.

Refund to Another Plan That Pays Primary

If another plan makes payments that should have been made by UMP Classic:

- UMP Classic may pay the other plan the amount UMP Classic should have paid.
- The amount UMP Classic pays is determined by nonduplication of benefits rules (see definition on page 110).
- Amounts paid by UMP Classic to the other plan are considered benefits paid by UMP Classic.

Payment for Diabetes Care Supplies When Another Plan Is Primary

If your primary coverage is under Medicare, see page 58.

UMP Classic covers diabetes care supplies only under the prescription drug benefit.

- If you get your supplies from a pharmacy, ask if the pharmacy can bill both UMP Classic and your primary plan. If so, you don't need to do anything further. If not, you will need to send a claim to Washington State Rx Services for secondary payment; see page 64 for instructions.
- If you get your supplies from a diabetic care supplier, the primary plan may process the claim as medical. In this case, you will need to send your Explanation of Benefits and a claim form to Washington State Rx Services for secondary payment; see page 64 for instructions.

NOTE: Nonduplication of benefits applies to these claims (see page 110), which means that UMP Classic may pay nothing additional after your primary plan has paid.

See also "Diabetes Care Supplies" on page 18 for more about this benefit.

ALERT! A secondary claim for diabetes care supplies submitted to Regence will be denied; the claim must be submitted to Washington State Rx Services.

How Does Coordination of Benefits Work With Prescription Drugs?

If you have primary medical coverage through another plan that covers prescription drugs, some of the limits and restrictions to prescription drug coverage listed on pages 37–40 will apply when UMP Classic pays secondary to another plan. See "Submitting a Claim for Prescription Drugs" beginning on page 64 for how to submit your prescription drug claim.

NOTE: If UMP Classic is secondary to another plan other than Medicare, nonduplication of benefits applies (see page 110). This means that UMP Classic may pay nothing after your primary plan pays.

ALERT! If UMP Classic is secondary, you must still pay your prescription drug deductible before UMP Classic covers Tier 2 and Tier 3 drugs.

Using Network Pharmacies When UMP Classic Is Your Secondary Coverage

If you have primary coverage through another plan that covers prescription drugs, show both plan cards to the pharmacy and make sure they know which plan is primary. It is important that the pharmacy bills the plans in the correct order, or claims may be denied or paid incorrectly.

Using Mail-Order Pharmacies When UMP Classic Is Secondary

See the Tip on page 61 on using the plan's network mail-order pharmacies when Medicare is your primary coverage.

If your primary plan uses one of the plan's network mail-order pharmacies (PPS or BioScrip), the pharmacy can process payments for both plans and charge you only what's left. Make sure that the mail-order pharmacy has your information for both plans and knows which plan is primary.

However, if your primary plan uses a different mail-order pharmacy, you will have to use your primary plan's mail order, then submit a paper claim for payment by UMP Classic; see "Submitting a Claim for Prescription Drugs" beginning on page 64 for how to do this. In this case, if you send your prescription to PPS or BioScrip, your prescription will be returned to you unfilled.

Whom Do I Inform If I Have Other Coverage?

If you or your dependents have other insurance, you must let Regence know so claims are paid correctly.

You may call Customer Service at 1-888-849-3681 (TTY: 711), or complete a Coordination of Benefits Form. The form is available at:

- **myRegence.com:** My Navigator, select Forms
- **The UMP website:** select Forms under Fast Find

Send the completed form to:

By fax: **1-877-357-3418**

By mail: **Regence BlueShield**
Attn: UMP Claims
PO Box 91015 MS BU386
Seattle, WA 98111-9115

Each person claiming payment for benefits under UMP Classic is required to give Regence any facts it needs to apply these coordination of benefits rules and determine the correct benefits payable. If your coverage under other plans changes, please call Customer Service right away.

UMP Classic Doesn't Pay for Occupational Injury or Illness

UMP Classic does not pay claims for services, drugs, or items related to occupational injury or illness (see definition on page 110).

For Retirees Enrolled in Medicare

When you see this symbol throughout this *Certificate of Coverage*, it gives specific tips for Medicare retirees.

Am I a Medicare Retiree?

You are considered a Medicare retiree if all of the following apply:

- Enrolled in Public Employees Benefits Board (PEBB) coverage as a retiree.
- Age 65 or older (or younger and eligible for Medicare due to medical disability).
- Enrolled in both Medicare Part A (hospital) and Part B (medical).

Because Medicare is the primary payer, there are a few rules that are different for Medicare retirees. This section tells you about these rules, including:

- How UMP Classic and Medicare work together.
- What UMP Classic covers that Medicare doesn't cover.
- What your choices for providers are.
- How billing works.
- How your prescription drug coverage works.
- Where to go for more information.

Retirees are required to enroll in Medicare Parts A and B when entitled to be eligible for PEBB coverage under UMP Classic. Your monthly premiums will be lower because Medicare pays part of your medical costs.

If you are retired but not yet enrolled in Medicare Parts A and B, this section does not apply to you. If you think you might be eligible for Medicare and need information on how to sign up, see the "Medicare Entitlement" section on page 94.

Note: Medicare accepts claims only from providers; you cannot submit a claim to Medicare.

How Do UMP Classic and Medicare Work Together?

Beginning January 1, 2012, Medicare retirees pay:

- An **inpatient copay** of $200 per day, $600 maximum per admission (no annual limit).
- A **medical out-of-pocket maximum** of $2,500 per calendar year (previously $2,000).

UMP Classic and Medicare are two separate health plans that work together to pay for covered health treatments and services. Here's how coordination of benefits works:

- Your providers bill Medicare. Medicare pays your claims first. After Medicare processes the claim, Medicare sends the claim to UMP Classic.
- UMP Classic pays your claims second. For most covered services, UMP Classic pays the rest of the Medicare allowed amount and you owe nothing.

ALERT! For the first services you receive each calendar year, you have to pay the UMP Classic medical deductible out-of-pocket ($250 per person, or no more than $750 for a family of three or more) before UMP Classic starts paying benefits.
Note: Claims apply to the UMP Classic medical deductible in the order they are processed, not necessarily in the order received by the member.

If UMP Classic covers a service or supply but Medicare doesn't (see "What Does UMP Classic Cover That Medicare Doesn't" on this page), UMP Classic pays as if it were the primary plan for those charges only.

Here's an example to show how this process works, after you have satisfied your UMP Classic medical deductible and Medicare deductible. This example assumes you received care from a network provider in Washington State, or a provider who accepts Medicare (has not "opted out" of Medicare) anywhere in the U.S.

Provider's charge	**$300**	
Medicare Benefit Calculation		
Medicare allowed amount:	$100	
Medicare pays:	$80	(80% of $100)
Remaining amount:	$20	
UMP Classic Benefit Calculation		
Plan allowed amount:	$100	
UMP Classic normal benefit:	$85	(85% of $100)
UMP Classic pays:	$20	
You pay:	**$0**	

In the example above, you owe nothing because the provider accepts Medicare. You may still have to pay coinsurance and deductible amounts when you have not fully paid your Medicare deductibles, or when Medicare does not cover a service.

If a provider does not bill Medicare, UMP Classic may not cover services. Medicare accepts claims from enrollees only under certain circumstances, and UMP Classic processes claims only after Medicare has processed them. (See "What Does UMP Classic Cover That Medicare Doesn't?" on this page for exceptions.) Ask your provider if he or she bills Medicare.

Payment for Diabetes Care Supplies When Medicare Is Primary

Medicare pays claims for diabetes care supplies under the medical plan; as a result, UMP Classic pays the claim under the durable medical equipment benefit. This means you will have to meet your medical deductible before UMP Classic begins to pay on diabetes care supplies claims, then UMP Classic pays its share based on medical benefit coinsurance (85% of the allowed amount for network providers and providers that accept Medicare).

See also "Diabetes Care Supplies" on page 18 for more about this benefit.

What Does UMP Classic Cover That Medicare Doesn't?

ALERT! Services listed below are covered based on whether the provider is network or non-network, and the specific benefit. For example, you pay nothing for preventive care services and covered immunizations (see pages 26–27) when you see a network provider. For most of the other services listed below, after you meet your UMP Classic medical deductible, you pay 15% of the allowed amount for network providers, and 40% of the allowed amount for non-network providers, plus any difference between the allowed amount and the provider's billed charges. In most cases, you will owe coinsurance for these services.

UMP Classic covers some services that Medicare doesn't cover at all. For these services, it doesn't matter if the provider accepts Medicare, because Medicare doesn't cover the service. You will receive the highest level of benefit if you choose a network provider.

Services not covered by Medicare Part A and Part B include but are not limited to:

- Acupuncture (see page 14).
- Hearing aids.

- Hearing exams for the purpose of getting a hearing aid (see page 21).
- Massage therapy (a massage therapist ***must*** be a network provider).
- Medical coverage outside the country; Medicare doesn't cover services outside of the U.S. (see pages 2–3 for details).
- Naturopathic medicine (see page 24).
- Prescription drugs (see "Use Network Pharmacies That Bill Medicare Part B Directly" on page 61 for exceptions).
- Routine vision exams and hardware (see page 30). (Medicare covers medical vision exams and vision hardware following cataract surgery.)
- Wigs for cancer patients (see page 19).

If you see a network provider, he or she will submit the claim for you. For non-network providers, check if the provider will submit the claim. If not, you will need to send a claim to UMP Classic. See "Billing & Payment: Filing a Claim" starting on page 63.

UMP Classic Covers More Than Medicare for Certain Services

UMP Classic covers some services after the Medicare benefit ends. These services include:

- Chemical dependency services (Medicare covers some substance abuse services under mental health).
- Inpatient hospital services.
- Mental health, both outpatient and inpatient services.
- Preventive care: Medicare covers some preventive services; see pages 26–27 for what UMP Classic covers.
- Skilled nursing facility services.

You may receive higher payment if you see network providers for these services. Call Customer Service at 1-888-849-3681 for more information.

ALERT! Network providers do not necessarily accept Medicare—you should ***always*** ask.

Should I See a Network Provider?

To find network providers outside the U.S., see pages 2–3.

Type of Service	Higher Benefits When You See A Network Provider?	Important Information
Services covered by Medicare	No	You should see a provider who accepts Medicare. See "When a Provider Doesn't Accept Medicare: Opt-Out Providers" on page 60 for more about why this is important.
Services covered by UMP Classic but not by Medicare (Exception: See information on massage therapy below.)	Yes	See "What Does UMP Classic Cover That Medicare Doesn't?" on page 58 to see which services apply. Use the Provider Search Tool online or call Customer Service to find a network provider.
Massage therapy	Yes	UMP Classic pays for massage therapy services only when the provider is in the network.
Prescription drugs	Yes	You must also choose pharmacies that participate in and can bill Medicare Part B directly because Medicare Part B covers a few drugs. See page 61 for more information.

When a Provider Doesn't Accept Medicare: Opt-Out Providers

When services are covered by Medicare, you must see providers who accept Medicare to get the services covered by Medicare and UMP Classic. If your provider has chosen to "opt out" of participating in Medicare, UMP Classic will not cover services by that provider, even if the provider is in the Regence or Blue Card network for UMP Classic members (see pages 2–3). Providers that "opt out" of Medicare are supposed to have you sign a "private contract" before providing services, but you are responsible for all costs even if you did not sign a contract.

When Do I Pay? How Billing Works

Most of the time, you pay ***after*** both Medicare and UMP Classic have processed your claim. Here's how it typically works:

1. Your provider bills Medicare.
2. Medicare processes the claim, and sends you an Explanation of Medicare Benefits (EOMB). The EOMB tells you how much Medicare paid on your claim.
3. Once Medicare has processed your claim, Medicare sends the claim to UMP Classic for processing. You do not need to submit a claim form or other paperwork to UMP Classic.
4. UMP Classic processes the claim and sends you an Explanation of Benefits (EOB). The EOB tells you how much UMP Classic paid, plus how much you owe the provider.
5. You receive a bill from your provider for any remaining amount due. To confirm that the provider has credited your account with both Medicare and UMP Classic payments:
   - Note the allowed amount on the Medicare EOMB.
   - Subtract both Medicare's and UMP Classic's payments from that amount; this should match the bill from your provider.
6. You pay your provider the amount due, if any. After you've met both your Medicare and UMP Classic deductibles, you won't pay anything for most claims.

If you haven't received any paperwork on a health care service within three months, call your provider's billing office and ask if they've sent the claim. Neither Medicare nor UMP Classic can process a claim they haven't received. While you are welcome to call UMP Classic and ask, if we haven't received the claim, we won't have any record of the service.

Some providers may ask you to pay at the time of services. In these cases, when you receive your UMP Classic Explanation of Benefits (EOB), check to make sure that the amount you paid matches the Patient Responsibility on the EOB.

How UMP Classic Prescription Drug Coverage Works With Medicare

FOR MORE INFORMATION: See "Your Prescription Drug Benefit" on pages 31–43 for complete information about your prescription drug coverage.

Use Network Pharmacies That Bill Medicare Part B Directly

We recommend that you choose a network pharmacy that can bill Medicare Part B directly to get the most from your prescription drug coverage. Medicare Part B does cover a few drugs and supplies for specific purposes; these drugs and supplies are identified on the *UMP Preferred Drug List*. **Note:** Medicare Part B quantity restrictions may apply.

Medicare accepts claims only from pharmacies, not from individuals. If Medicare covers a drug or supply and the pharmacy doesn't send the claim to Medicare first for payment, UMP Classic will reject the claim. To find a network retail pharmacy, see the pharmacy locator at **www.ump.hca.wa.gov** or call Washington State Rx Services at 1-888-361-1611.

If drugs or supplies are covered under Medicare Part B and paid as medical, UMP Classic also pays under the medical benefit. Therefore, UMP Classic's portion of the charges is subject to the medical deductible.

TIP: The plan's network mail-order pharmacies can bill Medicare Part B electronically on your behalf. Your claim will then be automatically submitted for secondary payment. You will be charged only for your coinsurance after both Medicare and UMP Classic have paid their portions. Using a network mail-order pharmacy means you won't have to worry about whether a drug or supply is covered by Medicare Part B. **Note:** Medicare Part B quantity restrictions may apply.

Can I Have UMP Classic and Medicare Part D?

No, you can't enroll in both UMP Classic and Medicare Part D. UMP Classic provides your prescription drug coverage so there's no need for you to enroll in a Part D plan. If you think you might want to change your coverage from UMP Classic to a Medicare supplement plan with Part D coverage, you should contact PEBB Benefits Services. See "Medicare Part D" on page 95 for more information.

Where Do I Go for More Information?

If you have questions about…	Contact…
◆ What Medicare covers ◆ Your Medicare deductibles and coinsurance amounts ◆ Medicare premiums ◆ Whether your claim has been processed by Medicare	Medicare 1-800-MEDICARE (1-800-633-4227) **www.medicare.gov** **www.MyMedicare.gov**
◆ What UMP Classic covers ◆ Your UMP Classic copays, coinsurance, and deductible amounts	UMP Customer Service 1-888-849-3681 **www.ump.hca.wa.gov**
◆ Your claim after it has been processed by Medicare	UMP Customer Service 1-888-849-3681 **www.myRegence.com**
◆ Prescription drugs	Washington State Rx Services 1-888-361-1611
◆ UMP Classic premiums ◆ Address changes ◆ Adding or dropping dependents on your account ◆ Changing your PEBB medical coverage	PEBB Benefits Services 1-800-200-1004 **www.pebb.hca.wa.gov**
◆ Whether your claim has been submitted to Medicare ◆ If the Patient Responsibility dollar amount on your UMP Classic Explanation of Benefits doesn't match your doctor's bill	Your doctor's billing office

Billing & Payment: Filing a Claim

Medicare-enrolled retirees: Be sure to read "For Retirees Enrolled in Medicare" starting on page 57.

When you enroll in UMP Classic, we will send you an identification (ID) card. The ID card will include important information such as the ID number, group number, and name of the member.

It is important to keep your ID card with you at all times. Be sure to present it to your provider before receiving care.

For additional or replacement cards, contact Customer Service at 1-888-849-3681 or order one at **www.myRegence.com**.

Submitting a Claim for Medical Services

When UMP Classic is your primary insurance and your provider is in the network, you don't need to submit claims; the provider will do it for you. If you have a question about whether your provider's office has submitted a claim, check **www.myRegence.com** or call Customer Service at 1-888-849-3681.

When Do I Need to Submit a Claim?

You may need to submit a claim to UMP Classic for payment if you receive services from a non-network provider or if you have other insurance that pays first and UMP Classic is secondary. **Note:** Medicare retirees, see pages 57–62.

Non-network providers may submit a claim on your behalf; ask the provider.

How Do I Submit a Claim?

TIP: If you purchase contact lenses or eyeglasses from a non-network provider that doesn't bill your plan, you will need to submit a claim for reimbursement. You can download the *Member Reimbursement Claim Form* at **www.ump.hca.wa.gov** or call Customer Service for a copy.

To submit a claim yourself, you'll need to obtain and mail the following documents:

1. The *Member Reimbursement Claim Form*—You can find the form online at **www.ump.hca.wa.gov** or you may request a form by calling Customer Service at 1-888-849-3681.
2. An itemized bill from your provider that describes the services you received and the charges.

   The following information must appear on the provider's itemized bill for the plan to consider the claim for payment:

   - Patient's name and plan ID number, including the alpha prefix (three letters before ID number).
   - Description of the injury or illness.
   - Date and type of service.
   - Provider's name, address, and phone number.
   - For ambulance claims, please also include where the patient was picked up and where he or she was taken.
3. If UMP Classic is secondary, you must include a copy of your primary plan's Explanation of Benefits, which lists the services covered and how much the other plan paid. Do not submit a secondary claim to UMP Classic until after the primary plan has paid.

Please note that if we have to request additional information, this may delay the processing of your claim.

Reimbursement for services received from a non-network provider may be sent to the provider or to you in the form of a check listing both you and the provider as payees.

Be sure to make copies of your documents for your records.

Mail both the claim form and the provider's claim document (or bill) to:

Regence BlueShield
PO Box 3027
Salt Lake City, UT 84130-0271

Call Customer Service at 1-888-849-3681 if you have a question about the processing of your claim.

Important Information About Submitting Claims

ALERT! You or your provider must submit claims within 12 months of the date you received health care services. The plan will not pay claims submitted more than 12 months after the date of service.

For more information about submitting claims for services outside of the United States, see "Services Received Outside the U.S." on page 2.

If you or a family member has other health care coverage, see "If You Have Other Medical Coverage" on pages 52–56 for information on how the plan coordinates benefits with other plans.

Claims Reimbursement

Most of the time, the plan will pay network providers directly. For claims submitted by you or a non-network provider, the plan will determine whether to pay you, the provider, or both you and the provider. For a child covered by a legal qualified medical child support order (QMCSO), the plan may pay the custodial parent or legal guardian of the child.

Claims Determinations

You will be notified of action taken on a claim within 30 days of the plan receiving it. This 30-day period may be extended by 15 days when action cannot be taken on the claim due to:

- Circumstances beyond the plan's control. Notification will include an explanation why an extension is necessary and when the plan expects to take action on the claim.
- Lack of information. The plan will notify you within the 30-day period that an extension is necessary, with a description of the information needed as well as why it is needed.

If the plan is asking you for additional information, you will be allowed at least 45 days to provide it. If the plan doesn't receive the information requested within the time allowed, the claim will be denied.

Submitting a Claim for Prescription Drugs

You may need to submit your own prescription drug claim to Washington State Rx Services for reimbursement if you:

- Purchase drugs at a non-network pharmacy.
- Fail to show your ID card at a network pharmacy.
- Get a prescription from a mail-order or internet pharmacy other than one of the plan's network mail-order pharmacies (see page 31).
- Have other prescription coverage that pays first and UMP Classic is secondary.

TIP: Vaccine claims submitted by a member must be sent to Regence (see page 63) as a medical claim; do not send to Washington State Rx Services.

Prescription drug claim forms are available online at **www.ump.hca.wa.gov** or by calling Washington State Rx Services at 1-888-361-1611. Send the completed claim form, along with your pharmacy receipt(s), to:

Washington State Rx Services
Attn: Pharmacy Claims
PO Box 40168
Portland, OR 97240-0168

It's a good idea to keep copies of all your paperwork for your records.

TIP: Foreign claims for prescription drugs must be translated into English with specific services, charges, drugs and dosage documented, and you must tell us the currency exchange rate. The plan does not pay for this documentation or translation.

When you submit a prescription drug claim to Washington State Rx Services, we pay the claim based on the following rules, no matter where you purchased the drug:

- We pay based on the allowed amount. If the pharmacy charges you more than the allowed amount, you will pay your usual coinsurance (and deductible and ancillary charge if applicable), plus the difference between what the plan paid and the pharmacy's charge.
- The plan pays all prescription drug claims, including non-network, based on coinsurance (as shown in the table on page 33).
- If your claim exceeds the quantity limit allowed by the plan or the maximum days' supply, the plan will pay only for the amount of the drug up to the quantity limit or maximum days' supply.
- If you receive a refill before 84% of the last supply you received should have been taken, the plan will not pay for it. This is called a "refill too soon" (see page 40).

You must submit prescription drug claims within 12 months of purchase. Claims for prescription drugs submitted more than 12 months after purchase will not be paid.

ALERT! If you do not show your plan ID card when purchasing a prescription at a Washington State Rx Services' network pharmacy, you will have to pay the full cash price and submit a *Prescription Drug Claim Form*. You won't receive the plan discount.

False Claims or Statements

Neither you nor your provider (or any person acting for you or your provider) may submit a claim for services or supplies that were not received, were resold to another party, or for which you are not expected to pay.

In addition, neither you nor any person acting for you may make any false or incomplete statements on any document for your plan coverage.

The plan may recover any payments or overpayments made as a result of a false claim or false statement by withholding future claim payments, by suing you, or by other means. False claims may also be crimes.

If you represent yourself as being enrolled in this plan when you are not, the plan will deny all claims.

What You Need to Know as a Plan Member

Your Rights and Responsibilities

To ensure UMP Classic offers the best possible medical care, we must work together with you and your providers as partners. To achieve this goal, you must know your rights and responsibilities.

As a plan member, you have the right to:

- Be treated with respect.
- Be informed by your providers about all appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.
- Have information about:
  - How new technology is evaluated for inclusion as a covered benefit.
  - How the plan reimburses providers.
  - Preauthorization and review requirements.
  - Providers you select and their qualifications.
  - The plan and network providers.
  - Your covered expenses, exclusions, and maximums or limits.
- Keep your medical records and personal information confidential.
- Get a second opinion about your provider's care recommendations.
- Make decisions with your providers about your health care.
- Make recommendations about member rights and responsibilities.
- Have a translator's assistance, if required, when calling the plan.
- Complain about or appeal plan services or decisions, or the care you receive.
- Receive:
  - All medically necessary covered services and supplies described in your *Certificate of Coverage*, subject to the maximums, limits, exclusions, deductibles, coinsurance, and copayments.
  - Courteous, prompt answers from the plan.
  - Timely, proper medical care without discrimination of any kind—regardless of health status or condition, sex, ethnicity, race, marital status, or religion.
  - Written explanation from the plan about any request to refund an overpayment.

As a plan member, you have the responsibility to:

- Confirm your provider's network status before *every* visit.
- Enroll in Medicare Parts A and B as soon as you are entitled.
- Comply with requests for information by the date given.
- Follow your providers' instructions about your health care.
- Give your providers complete information about your health to get the best possible care.
- Know how to access emergency care.
- Not engage in fraud or abuse in dealing with the plan or your providers.
- Participate with your providers in making decisions about your health care.
- Pay your copayments, coinsurance, and deductibles promptly.

- Refund promptly any overpayment made to you or for you.
- Report to the plan any outside sources of health care coverage or payment.
- Return your completed Multiple Coverage Inquiry questionnaire you receive from the plan in a timely manner to prevent delay in claims payment.
- Understand your plan benefits, including what's covered, preauthorization and notification requirements, and other information described in this *Certificate of Coverage*.
- Use network providers when available.

Information Available to You

We support the goal of giving you and your family the detailed information you need to make the best possible health care decisions. You can find the following information in this *Certificate of Coverage*:

- List of covered expenses (see pages 14–30).
- Benefit exclusions, reductions, and maximums or limits (see pages 47–51).
- Clear explanation of complaint and appeal procedures (see pages 69–74).
- Preventive health care benefits that are covered (see pages 26–27).
- Definition of terms (see pages 101–115).
- Process for preauthorization or review (see page 37 and pages 44–45).
- Policies regarding drug coverage and how the plan adds and removes drugs from the *UMP Preferred Drug List* (see pages 31–43).

You can get the following information at **www.ump.hca.wa.gov** or by calling Customer Service:

- Directory of network providers, including both primary care providers and specialists.
- Preferred drug list.
- Claims history and deductible status.
- Information on the plan's care management programs.
- When the plan may retroactively deny coverage for preauthorized care.
- Notice of privacy practices (includes plan policy for protecting the confidentiality of health information; see page 68).
- Procedures to follow for consulting with providers.
- General reimbursement or payment arrangements between the plan and network providers.
- Description and justification for provider compensation programs, including any incentives or penalties intended to encourage providers to withhold services.
- How you can be involved in decisions about benefits.
- Accreditation information, including measures used to report the plan's performance such as consumer satisfaction survey results or Health Plan Employer Data and Information Set (HEDIS) measures.
- Documents and other materials referred to in PEBB open enrollment materials or this *Certificate of Coverage*.

You may also call Customer Service for an annual accounting of all payments made by the plan that have been counted against any payment limits, day limits, visit limits, or other limits on your coverage. The plan will provide a written summary of payments within 30 calendar days of your request. Some of this information is also available at **www.myRegence.com**.

The plan does not prevent or discourage providers from telling you about the care you require, including various treatment options and whether the provider thinks that care is consistent with the plan's coverage criteria. You may, at any time, get health care outside of plan coverage for any reason; however, you must pay for those services and supplies. In

addition, the plan does not prevent or discourage you from talking about other health plans with your provider.

Confidentiality of Your Health Information

The plan follows our *Notice of Privacy Practices,* available online at **www.ump.hca.wa.gov** or by calling Customer Service. The plan will release member health information only as described in that notice or as required or permitted by law or court order.

Release of Information

The plan or Washington State Health Care Authority may require you to give information when needed to determine eligibility, administer benefits, or process claims. This could include medical and other records. The plan could deny coverage if you don't provide the information when requested.

Complaint and Appeal Procedures

For more information: If you have any questions about appeals or complaints, you may contact us at:

Medical Services
1-888-849-3681

Uniform Medical Plan
PO Box 2998
Tacoma, WA 98401-2998

Prescription Drugs
1-888-361-1611

Washington State Rx Services
Attn: Appeals
PO Box 40168
Portland, OR 97240-0168

ALERT! Appeals procedures are subject to change during the year if required by Washington State law.

What Is a Complaint or Grievance?

A complaint (also called a grievance) is an oral or written expression of dissatisfaction submitted by or for a member about:

- Denial of coverage or payment for health care services or prescription drugs.
- Delays in service or conflicts with the plan or providers.
- Plan practices or actions unrelated to health care services or prescription drugs.
- Customer service or the quality or availability of a health service.

What Is an Appeal?

An appeal is an oral or written request sent by you or your authorized representative to Regence BlueShield or Washington State Rx Services to reconsider a previous decision about:

- Resolution of your complaint.
- Claims payment, processing, or reimbursement for health care services.
- A decision to deny, modify, reduce, or terminate payment, coverage, certification, or provision of health care services or benefits, including the admission to, or continued stay in, a health care facility.
- A retroactive decision to deny coverage based on eligibility; see "Appeals Related to Eligibility" on page 74.

The Appeals Process

ALERT! If your appeal is for an urgent or life-threatening condition, see "Expedited Appeals" beginning on page 71.

You may appeal yourself, or an authorized representative (see pages 102–103) may request an appeal for you. There are three parts to the appeals process: first-level appeal, second-level appeal, and independent review.

If your request involves a decision to change, reduce, or terminate coverage for services, supplies, or prescription drugs already being covered, the plan must continue coverage for these services during your appeal. However, if the plan or the Health Care Authority upholds the decision to change, reduce, or terminate

coverage, you will be responsible for any payments made by the plan during that period. If you request payment for denied claims or approval of services, supplies, or prescription drugs not yet covered by the plan, we do not have to cover the services, supplies, or prescription drugs while the appeal is under consideration.

The plan will consult with a health care professional on appeals where the plan's decision was based in whole or in part on a medical judgment. That includes decisions based on determinations that a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate. In this case, the plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved.

You may send written comments, documents, and any other information when you request an appeal. You may also request copies of documents the plan has that are relevant to your appeal, which the plan will provide at no cost. Our review will consider any information you or your provider submits to us.

How to File a Complaint or Appeal

You can send a complaint or appeal **by telephone, mail, fax, or email** (see contact information on page 72). If you send a written complaint or appeal, the plan will send confirmation within five business days of receiving it. You will also receive notice of the action on your complaint or appeal within 30 calendar days. We will ask your permission if we need more time to respond.

Information to Provide With an Appeal

Your appeal will be handled more quickly if you provide all the necessary information when you file it. Please include the following information when requesting an appeal:

- The subscriber's full name (the name of the employee or retiree covered by the plan).
- The patient's full name (the name of the employee, retiree, or family member covered by the plan).
- The subscriber's ID number (starting with a "W" on your ID card).
- The name(s) of any providers involved in the issue you are appealing.
- The dates when services were provided.
- Your mailing address.
- Your daytime phone number(s).
- A statement of what the issue is and what you are asking for.
- A copy of the Explanation of Benefits, if applicable.
- Medical records from your provider, if applicable. For cases in which the denial of coverage is based on medical necessity or other clinical reasons, your provider should supply clinically relevant information such as medical records or any other relevant information along with your appeal. Because of the time limits on deciding appeals, getting this information in advance will help us make the most accurate decision on your case.

First-Level Appeals

You may request a first-level appeal orally or in writing, no more than 180 days after you receive notice of the action leading to the appeal. Although you may request an appeal by phone or in person, putting your appeal in writing will help us make more informed decisions. If you don't appeal within this time period, you will not be able to continue to pursue the appeal process and may jeopardize your ability to pursue the matter.

First-level appeals for medical services are handled by Regence BlueShield and first-level appeals for prescription drugs are handled by Washington State Rx Services. Employees from Regence and Washington State Rx Services handling the appeals will not have been involved in the initial decision you are appealing. Claim processing disputes will be reviewed by a complaint and appeals analyst. Appeals about covering, authorizing, or providing health care will be evaluated by the staff of health care professionals at Regence or Washington State Rx Services.

ALERT! Deadlines for submitting an appeal are based on the first date you are notified of how a claim processed, usually when the plan sends you an Explanation of Benefits (including services that applied to the deductible or were denied). The plan does not waive deadlines based on untimely billing by your provider.

Second-Level Appeals

If you disagree with the decisions made on your first-level appeal, you may request a second-level appeal. Second-level appeals must be submitted no more than 180 days after the date of the letter responding to your first-level appeal. If you don't appeal within this time period, you will not be able to continue to pursue the appeal process and may jeopardize your ability to pursue the matter.

Second-level appeals for medical services are reviewed by a panel of Regence BlueShield employees, and second-level appeals for prescription drugs are handled by Washington State Rx Services. Employees from Regence and Washington State Rx Services handling the appeals will not have been involved in, or subordinate to anyone involved in, the first-level decision. You, or your representative on your behalf, will be given a reasonable opportunity to provide written testimony for the panel to consider.

TIP: Because of privacy laws, the plan usually cannot share information on appeals or complaints with family members or other persons unless the patient is a minor, or the plan has received written authorization to release personal health information to the other person. If you want to authorize someone to receive your protected health information or designate a representative, you may request an *Authorization to Disclose Protected Health Information* form from Customer Service. This form must be returned to the address on the form before the plan can share information. If you are designating someone else to represent you in an appeal or complaint, the authorization form must specifically state this.

Expedited Appeals

Expedited Appeals for Medical Services for Claims Involving Urgent Care

If the plan denies coverage for services and your provider determines that taking the usual time allowed could seriously affect your life, health, or ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the care or treatment, ask your provider to request an expedited appeal. Your provider must submit all clinically relevant information to the plan by phone or fax at:

Phone: 1-888-849-3681
Fax: 1-877-663-7526 (providers only)

Expedited Appeals for Prescription Drugs

If your provider thinks that you need a medication immediately, he or she may request an expedited review. This means that Washington State Rx Services will decide regarding coverage of the drug within 72 hours of the request. In this case, you may choose to purchase a three-day supply at your own expense. If Washington State Rx Services' decision is to cover the drug, Washington State Rx will reimburse you up to the allowed amount

minus the enrollee cost-share (coinsurance and the prescription deductible and ancillary charge if applicable). If Washington State Rx decides not to cover the drug, you are responsible for the cost of the drug.

Phone: 1-888-361-1611
Fax: 1-866-923-0412

Where to Send Complaints or Appeals About Medical Services

By phone:

Uniform Medical Plan
Customer Service
1-888-849-3681 (TTY 711)
Monday through Friday
7 a.m. to 5 p.m. Pacific Time

By mail:

Uniform Medical Plan
PO Box 2998
Tacoma, WA 98401-2998

Email:

Via www.myRegence.com

Fax:

1-877-663-7526

Where to Send Complaints or Appeals About Prescription Drugs

Washington State Rx Services
Attn: Appeals
PO Box 40168
Portland, OR 97240-0168

Phone: 1-888-361-1611
Fax: 1-866-923-0412

We recommend calling first with a complaint or appeal about prescription drugs, since many problems can be resolved quickly over the phone.

Time Limits for the Plan to Decide Appeals

The time limits below apply to both first- and second-level appeals, and are calculated from when the appeal is received.

- The plan will send written confirmation of your appeal to you within five business days of receiving it.
- The plan will decide on your appeal within 30 days unless a shorter time limit applies as explained below. We will request written permission from you or your representative when we need an extension to the 30-day timeline, to get medical records or a second opinion.
- In appeals involving a denial of a preauthorization request, we will decide within 14 calendar days.
- When your provider determines a delay could seriously jeopardize your life, health, or ability to regain maximum function, or that delay would cause severe pain that could not be adequately managed without the care or treatment you are appealing, we will decide as soon as possible but always within 72 hours. We will notify you (or your authorized representative) of our decision verbally within 72 hours, and will mail a written notification within three days of the decision.
- If the adverse benefit decision was based on the conclusion that the service, drug, or device is experimental or investigational, the appeal decision will be made within 20 business days. If a shorter time limit applies under other provisions of this Certificate of Coverage, the shorter time limit applies.

ALERT! The plan will comply with shorter time limits than those above when required by Washington State law.

Independent Review

You may request an external or independent review ***only*** when the denial is based on one of the following:

- Medical necessity
- Appropriateness
- Health care setting
- Level of care
- Effectiveness of a covered benefit

If you have gone through both a first- and second-level appeal and your appeal was based on one of the issues listed above, you may request an external or independent review in the following situations:

- If the plan has exceeded the timelines for response to your appeal without good cause and without reaching a decision.
- If you are dissatisfied with the decision of your second-level appeal.
- If the plan has failed to strictly adhere to the requirements of the appeals process.

You must request an independent review no more than four months after the date of the letter responding to your second-level appeal. The enrollee or an authorized representative (see pages 102–103) can request an independent review.

TIP: An Independent Review Organization (IRO) will conduct the external review. An IRO is a group of medical and benefit experts certified by the Washington State Department of Health and not related to the plan, Regence BlueShield, Washington State Rx Services, or the Health Care Authority. An IRO is intended to provide unbiased, independent clinical and benefit expertise as well as evidence-based decision making while ensuring confidentiality. The IRO reviews your appeal to determine if the plan's decision is consistent with state law and the *UMP Classic Certificate of Coverage*. The plan will pay the IRO's charges.

To request an independent review for medical services, contact the plan at:

Uniform Medical Plan
PO Box 2998
Tacoma, WA 98401-2998

Fax: 1-877-663-7526
Phone: 1-888-849-3681 (TTY 711)

Regence will send the Independent Review Organization the relevant medical information and correspondence.

To request an independent review for prescription drugs, contact the plan at:

Washington State Rx Services
Attn: Appeals
PO Box 40168
Portland, OR 97240-0168

Phone: 1-888-361-1611
Fax: 1-866-923-0412

You must go through the first and second levels of appeal before you can request an independent review or pursue litigation. You may pursue litigation against UMP or the Health Care Authority:

- Instead of requesting an independent review.
- After an independent review decision.
- When your appeal is not eligible for an independent review.

Complaints About Quality of Care

For complaints or concerns about the quality of care you received from a network provider, you may contact Customer Service by:

Phone: 1-888-849-3681 (TTY 711)
Secure email through your account at www.myRegence.com

Or you may contact the Washington State Department of Health regarding any provider (network or non-network) you have a concern about by:

Phone: 360-236-4700
Email: HSQAComplaintIntake@doh.wa.gov
Website:
www.doh.wa.gov/hsqa/complaint.htm

Appeals Related to Eligibility

Appeals related to eligibility and enrollment are handled by the Public Employees Benefits Board (PEBB) Program and governed by WAC chapter 182-16. Information on how to file an appeal is available:

- On the PEBB website at **www.pebb.hca.wa.gov**.
- By contacting the PEBB Appeals Manager at 1-800-351-6827.

When Another Party Is Responsible for Injury or Illness

Coverage under the plan is not provided for medical, dental, or vision expenses you incur for treatment of an injury or illness if the costs associated with the injury or illness may be recoverable from any of the following:

- A third party; or
- Any other source, including no fault automobile medical payments ("Med-Pay"), no fault automobile personal injury protection ("PIP"), homeowner's no-fault coverage, commercial premises no-fault medical coverage or similar contract or insurance, when the contract or insurance is either issued to, or makes benefits available to you, whether or not you make a claim under such coverage; or
- Services or supplies for work-related injury or illness, even if the service or supply is not a covered workers' compensation benefit.

However, if you have a potential right of recovery for illnesses or injuries from a third party who may have legal responsibility or from any other source, benefits may be advanced by the plan pending the resolution of a claim to the right of recovery if all the following conditions apply:

- By accepting or claiming benefits, you agree that the plan is entitled to reimbursement of the full amount of benefits paid out of any settlement or recovery from any source to the extent that the settlement or recovery exceeds full compensation to you for the injury or illness that you sustained. This includes any arbitration award, judgment, settlement, disputed claim settlement, underinsured or uninsured motorist payment or any other recovery related to the Injury or Illness for which benefits under the plan have been provided.
- The plan may choose to recover expenses through subrogation to the extent that the settlement or recovery exceeds full compensation to you for the injury or illness that you sustained. The plan is authorized, but not obligated, to recover any benefits to the extent that were paid under the plan directly from any party liable to you, upon mailing of a written notice to the potential payer, to you or to your representative.
- The plan's rights apply without regard to the source of payment for medical expenses, whether from the proceeds of any settlement, arbitration, award, or judgment; or other characterization of the recovery by the claimant or any third party or the recovery source. The plan is entitled to reimbursement from the first dollars received from any recovery to the extent that the settlement or recovery exceeds full compensation to you for the injury or illness that you sustained. This applies regardless of whether:
  - The third party or third party's insurer admits liability;
  - The health care expenses are itemized or expressly excluded in the recovery; or
  - The recovery includes any amount (in whole or in part) for services, supplies, or accommodations covered under the plan.

- You may be required to sign and deliver all legal papers and take any other actions requested to secure the plan's rights (including an assignment of rights to pursue your claim if you fail to pursue your claim of recovery from the third party or other source). If you are asked to sign a trust agreement or other document to reimburse the plan from the proceeds of any recovery, you will be required to do so as a condition to advancement of any benefits.
- You must agree that nothing will be done to prejudice the plan's rights and that you will cooperate fully with the plan, including signing any documents within the required time and providing prompt notice of any settlement or other recovery. You must notify the plan of any facts that may impact the right to reimbursement or subrogation, including, but not necessarily limited to, the following:
  - The filing of a lawsuit;
  - The making of a claim against any third party;
  - Scheduling of settlement negotiations in accordance with the plan (including, but not necessarily limited to, a minimum of 21 days advance notice of the date, time, location and participants to be involved in any settlement conferences or mediations); or
  - Intent of a third party to make payment of any kind to your benefit or on your behalf and that in any manner relates to the Injury or Illness that gives rise to the plan's right of reimbursement or subrogation (notification is required a minimum of five business days before the settlement).
- You and your agent or attorney must agree to keep segregated in its own account any recovery or payment of any kind to your benefit that in any manner relates to the injury or illness giving rise to the plan's right of reimbursement or subrogation, until the plan's right is satisfied or released.
- In the event you or your agent or attorney fails to comply with any of these conditions, any such benefits advanced for any illness or injury may be recovered through legal action to the extent that the settlement or recovery exceeds full compensation to you for the injury or illness that you sustained.
- Any benefits provided or advanced under the plan are provided solely to assist you. By paying such benefits, the plan is not waiving any right to reimbursement or subrogation.

Services Covered by Other Insurance

The plan does not cover services that are covered by other insurance, including but not limited to no fault automobile medical payments ("Med-Pay"), no fault automobile personal injury protection ("PIP"), homeowner's no fault coverage, commercial premises no fault medical coverage, underinsured or uninsured motorist coverage or similar contract or insurance. You are responsible for any cost-sharing required under the other coverage as allowed by state law. Once you have exhausted benefits (for example, reached the maximum medical expenses amount of the other insurance policy(ies), or services are no longer injury-related, the plan will cover services according to this certificate of coverage.

Motor Vehicle Coverage

If you are involved in a motor vehicle accident, whether as a driver, passenger, pedestrian, or other capacity, you may have rights under multiple motor vehicle insurance no fault coverages and also against a third party who may be responsible for the accident. In that case, this right of reimbursement and subrogation provision still applies.

Fees and Expenses

You may incur attorney's fees and costs in connection with obtaining a recovery. We shall pay a proportional share of such attorney's fees and costs incurred by you at the time of any settlement or recovery to otherwise reduce the amount of reimbursement paid to the plan to less than the full amount of benefits paid by the plan.

Future Medical Expenses

Benefits for otherwise covered services may be excluded, as follows:

- When you have received a recovery from another source relating to an illness or injury for which benefits under the plan have been previously paid.
- Until the total amount excluded under this subrogation provision equals the third-party recovery.

The amount of any exclusion or recovery under this provision, however, will not exceed the amount of benefits previously paid to the extent that your total settlement or recovery exceeds full compensation to you for the injury or illness that you sustained.

Eligibility and Enrollment for Active Employees

Eligibility

Eligibility for Public Employees Benefits Board (PEBB) benefits is based on rules in Washington Administrative Code (WAC) chapters 182-08 and 182-12. These rules can be found at **www.pebb.hca.wa.gov** in the PEBB Rules and Policies section of the website.

Eligible Employees

Employees (referred to in the Eligibility and Enrollment sections as "employees," "subscribers" or "enrollees") are eligible for enrollment in Public Employees Benefits Board (PEBB) medical plans as described in WAC 182-12-114.

Eligible Dependents

To enroll in a health plan a dependent must be eligible under WAC 182-12-260 and the subscriber must follow the enrollment requirements outlined in WAC 182-12-262.

The PEBB Program verifies the eligibility of all dependents and reserves the right to request documents from subscribers that prove a dependent's eligibility. The PEBB Program will remove a subscriber's dependents from health plan enrollment if the PEBB Program is unable to verify a dependent's eligibility. The PEBB Program will not enroll or reenroll dependents into a health plan if the PEBB Program is unable to verify a dependent's eligibility.

The following are eligible as dependents under the PEBB eligibility rules:

1. Lawful spouse.
2. Effective January 1, 2010, Washington State-registered domestic partners, as defined in RCW 26.60.020(1).
3. Children. Children are defined as the subscriber's biological children, stepchildren, legally adopted children, children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child, children of the subscriber's Washington State-registered domestic partner, or children specified in a court order or divorce decree.

   In addition, children include extended dependents in the legal custody or legal guardianship of the subscriber, the subscriber's spouse, or subscriber's Washington State-registered domestic partner. The legal responsibility is demonstrated by a valid court order and the child's official residence with the custodian or guardian. "Children" does not include foster children for whom support payments are made to the subscriber through the state Department of Social and Health Services foster care program.

   Eligible children include:

   a. Children up to age 26.
   b. Effective January 1, 2011, children of any age with a disability, mental illness, or intellectual or other developmental disabilities who are incapable of self-support, provided such

condition occurs before age 26. Also note:

- The subscriber must provide evidence of the disability and evidence that the condition occurred before age 26.
- The subscriber must notify the PEBB Program in writing no later than 60 days after the date that a child age 26 or older no longer qualifies under this eligibility. For example, children with a disability who become self-supporting are not eligible as of the last day of the month in which they become capable of self-support.
- Children age 26 and older who become capable of self-support do not regain eligibility under these criteria if they later become incapable of self-support.
- The PEBB Program will certify the eligibility of children with disabilities periodically.

ALERT! Don't forget! Notify the PEBB Benefits Services Program at 1-800-200-1004 as soon as possible of changes in dependent status. You may be required to pay for services received by ineligible dependents.

4. Parents.
   a. Parents covered under a PEBB medical plan before July 1, 1990, may continue enrollment on a self-pay basis as long as all of the following are met:
      - The parent maintains continuous enrollment in a PEBB medical plan;
      - The parent qualifies under the Internal Revenue Code as a dependent of the subscriber;
      - The subscriber continues enrollment in PEBB insurance coverage; and
      - The parent is not covered by any other group medical plan.

   b. Parents eligible under this subsection may be enrolled with a different medical plan than that selected by the subscriber. Parents may not enroll additional dependents to their insurance coverage.

Enrollment

TIP: When you retire, be sure to enroll in PEBB retiree coverage within 60 days of your retirement date. Retirees may defer medical coverage if they have other employment that provides comprehensive medical coverage. If you do not enroll or formally defer PEBB coverage within 60 days of retirement, you will not be able to return to PEBB coverage later.

PEBB enrollment rules are described in chapters 182-08 and 182-12 WAC. These rules can be found at **www.pebb.hca.wa.gov** in the PEBB Rules and Policies section of the website.

An employee or dependent is eligible to enroll in only one PEBB medical plan even if eligibility criteria are met under two or more subscribers. For example, a dependent child who is eligible for enrollment under two or more parents working for employers that participate in PEBB coverage may be enrolled as a dependent under one parent, but not more than one.

Employees may waive enrollment in a PEBB medical plan if they are enrolled in other comprehensive group medical coverage. If an employee waives enrollment in a PEBB medical plan, the employee cannot enroll eligible dependents.

How to Enroll

ALERT! Subscribers may change health plans at the following times:

- **During annual open enrollment:** Subscribers may change health plans during the annual open enrollment; see page 81.
- **During a special open enrollment:** Subscribers may change health plans outside of the annual open enrollment if a special open enrollment event occurs; see pages 81–84.

Employees must submit an *Employee Enrollment/Change* form to their employing agency no later than 31 days after the date the employee becomes eligible for PEBB benefits. If the employee does not meet this requirement, the employee will be enrolled in the Uniform Medical Plan Classic, and any eligible dependents cannot be enrolled until the next open enrollment.

If an employee wants to enroll his or her eligible dependent(s) when the employee becomes eligible to enroll in PEBB benefits, the employee must include the dependent's enrollment information on the appropriate forms within the relevant time limits described in WAC 182-08-197. In addition, the employee must provide the required document(s) as evidence of the dependent's eligibility.

An employee or his or her dependents may enroll during the annual open enrollment (see "Annual Open Enrollment" on page 81) or during a special open enrollment (see Special Open Enrollment section), if the change in enrollment corresponds to the event that creates the special open enrollment for either the employee or the employee's dependent or both. The employee must provide evidence of the event that created the special open enrollment.

When Medical Enrollment Begins

For an employee and the employee's eligible dependent, enrolled when the employee is newly eligible, medical plan enrollment will begin when the employee's insurance coverage begins as described in WAC 182-12-114.

For an employee or an employee's eligible dependent enrolled during the annual open enrollment, medical coverage will begin on January 1 of the following year.

For an employee or an employee's eligible dependent enrolled during a special open enrollment, medical coverage will begin the first day of the month following the later of the event date or the date the form is received.

Exceptions:

1. If adding a child due to birth or adoption (or subscriber assuming a legal obligation for total or partial support in anticipation of adoption), medical coverage will begin on the day the child is born or adopted.
2. If adding a child who becomes eligible as an extended dependent through legal custody or legal guardianship, or a child who becomes eligible as a dependent with a disability, medical coverage will begin on the first day of the month following eligibility certification.

Removing Dependents

ALERT! Failure to notify your payroll office or PEBB of changes in status affecting eligibility may result in termination of coverage. You are responsible for the cost of any services received when you or your dependent(s) were ineligible.

Employees are required to notify their employing agency to remove dependents no later than 60 days from the date a dependent no longer meets the eligibility criteria described under Eligible Dependents (WAC 182-12-250 or WAC 182-12-260).

Consequences for not submitting notice within 60 days may include, but are not limited to:

- The dependent may lose eligibility to continue health plan coverage under one of the continuation coverage options described in WAC 182-12-270;
- The subscriber may be billed for claims paid by the health plan for services that were rendered after the dependent lost eligibility;
- The subscriber may not be able to recover subscriber-paid insurance premiums for dependents that lost their eligibility; and
- The subscriber may be responsible for premiums paid by the state for the dependent's health plan coverage after the dependent lost eligibility.

TIP: Keeping your address and other personal information up-to-date helps ensure that you receive important notices about your benefits. If your address or name changes:

- Employees should notify their payroll office as soon as possible.
- Retirees (and other self-pay enrollees) should contact PEBB Customer Service at 1-800-200-1004.

Annual Open Enrollment

Employees may make changes to their enrollment during any PEBB annual open enrollment period as long as they submit the change within required time limits. During the annual open enrollment employees may make a change to their enrollment as follows:

- Enroll in or waive his or her enrollment in a medical plan;
- Enroll or remove eligible dependents; or
- Change medical plan choice.

The employee must submit the appropriate change form to their employing agency no later than the end of the annual open enrollment (usually November 30). The enrollment change will become effective January 1 of the following year.

Special Open Enrollment

TIP: You may be eligible to change medical plans if you move during the calendar year. See the list of special open enrollment events beginning below for details.

Employees may change their enrollment outside of the annual open enrollment if a special open enrollment event occurs. However, the Internal Revenue Code (IRC) must allow the change and it must correspond to the event that creates the special open enrollment for either the employee or the employee's dependent (or both).

To make an enrollment change, the employee must submit the appropriate form(s) to his or her employing agency no later than 60 days after the event that created the special open enrollment. In addition to the appropriate forms, the PEBB Program or employing agency may require the employee to prove eligibility or provide evidence of the event that created the special open enrollment.

ALERT! See "Adding a New Dependent to Your Coverage" on page 25.

Exception: If an employee wants to enroll a newborn or child whom the subscriber has adopted (or has assumed a legal obligation for total or partial support in anticipation of adoption), the employee should notify their employer by submitting an enrollment form as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the subscriber must submit the appropriate enrollment form no later than 12 months after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption. Employees should contact their payroll,

personnel or insurance office to obtain the appropriate forms.

ALERT! If an enrollee's provider or health care facility discontinues participation with this plan, the enrollee may not change medical plans until the next open enrollment period, unless the PEBB Appeals Manager determines that a continuity of care issue exists. The plan cannot guarantee that any one physician, hospital, or other provider will be available or remain under contract with us. Also, if an employee transfers from one employing agency to another during the year, the enrollee cannot change medical plans, except as outlined above or in WAC 182-08-197.

An eligible qualifying event must occur to create a special open enrollment that allows an employee to:

- Enroll in or change his or her health plan,
- Waive his or her health plan enrollment, or
- Enroll or remove eligible dependents

When can an employee enroll in or change his or her health plan?

Any one of the following events may create a special open enrollment:

1. Employee acquires a new dependent due to:
   a. Marriage or registering a domestic partnership with Washington's Secretary of State,
   b. Birth, adoption or when the subscriber assumes a legal obligation for total or partial support in anticipation of adoption,
   c. A child becomes eligible as an extended dependent through legal custody or legal guardianship, or
   d. A child becomes eligible as a dependent with a disability.
2. Employee or an employee's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);
3. Employee or an employee's dependent has a change in employment status that affects the employee's or the employee's dependent's eligibility for the employer contribution toward group health coverage;
4. Employee or an employee's dependent has a change in residence that affects health plan availability. If the employee moves and the employee's current health plan is not available in the new location the employee must select a new health plan. If the employee does not select a new health plan within the required time limits the PEBB Program will enroll the employee in a health plan as described in WAC 182-08-196;
5. Employee receives a court order or medical support order requiring the employee, the employee's spouse, or employee's Washington State-registered domestic partner to provide insurance coverage for an eligible dependent (a former spouse or former qualified or registered domestic partner is not an eligible dependent);
6. Employee or an employee's dependent becomes eligible for state premium assistance through Medicaid or a state children's health insurance program (CHIP), or the employee or dependent loses eligibility for coverage under Medicaid or CHIP;
7. Employee or an employee's dependent becomes entitled to Medicare, enrolls in or disenrolls from a Medicare Part D plan. If the employee's current health plan becomes unavailable due to the employee's or an employee's dependent's entitlement to Medicare, the subscriber must select a new health plan as described in WAC 182-08-196;
8. Employee or an employee's dependent's current health plan becomes unavailable because the subscriber or enrolled

dependent is no longer eligible for a health savings account (HSA). HCA may require evidence that the subscriber or subscriber's dependent is no longer eligible for an HSA;

9. Employee experiences a disruption that could function as a reduction in benefits for the employee or the employee's dependent(s) due to a specific condition or ongoing course of treatment. An employee may not change his or her health plan if the employee's or an enrolled employee's physician stops participation with the employee's health plan unless the PEBB Program determines that a continuity of care issue exists. The PEBB Program criteria used will include, but is not limited to, the following:
   a. Active cancer treatment; or
   b. Recent transplant (within the last 12 months); or
   c. Scheduled surgery within the next 60 days; or
   d. Major surgery within the previous 60 days; or
   e. Third trimester of pregnancy; or
   f. Language barrier.

   If the employee is having premiums taken from payroll on a pretax basis, a plan change will not be approved if it would conflict with provisions of the salary reduction plan authorized under RCW 41.05.300.

When can an employee waive his or her medical plan enrollment?

Any one of the following events may create a special open enrollment:

1. Employee acquires a new dependent due to:
   a. Marriage or registering a domestic partnership with Washington's Secretary of State,
   b. Birth, adoption or when the employee has assumed a legal obligation for total or partial support in anticipation of adoption,
   c. A child becoming eligible as an extended dependent through legal custody or legal guardianship, or
   d. A child becoming eligible as a dependent with a disability.
2. Employee or an employee's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);
3. Employee or an employee's dependent has a change in employment status that affects the employee's or employee's dependent's eligibility for the employer contribution toward group health coverage;
4. Employee receives a court order or medical support order requiring the employee, the employee's spouse, or employee's Washington State-registered domestic partner to provide insurance coverage for an eligible dependent (a former spouse or former qualified or registered domestic partner is not an eligible dependent);
5. Employee or an employee's eligible dependent becomes eligible for state premium assistance through Medicaid or a state children's health insurance program (CHIP), or the employee or an employee's dependent loses eligibility for coverage under Medicaid or CHIP.

When can an employee enroll or remove eligible dependents?

Any one of the following events may create a special open enrollment:

1. Employee acquires a new dependent due to:
   a. Marriage or registering a domestic partnership with Washington's Secretary of State,
   b. Birth, adoption or when an employee has assumed a legal obligation for total

or partial support in anticipation of adoption,

c. A child becoming eligible as an extended dependent through legal custody or legal guardianship, or

d. A child becoming eligible as a dependent with a disability.

2. Employee or an employee's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);

3. Employee or an employee's dependent has a change in employment status that affects the employee's or employee's dependent's eligibility for the employer contribution toward group health coverage;

4. Employee receives a court order or medical support order requiring the employee, the employee's spouse, or employee's qualified or Washington State-registered domestic partner to provide insurance coverage for an eligible dependent (a former spouse or former qualified or registered domestic partner is not an eligible dependent);

5. Employee or an employee's dependent becomes eligible for state premium assistance through Medicaid or a state children's health insurance program (CHIP), or the employee or dependent loses eligibility for coverage under Medicaid or CHIP.

Medicare Entitlement

Retirees, permanently disabled employees, and eligible dependents must enroll in Medicare Part A and Part B if entitled.

If an enrollee becomes entitled to Medicare, he or she should contact the nearest Social Security Administration Office to inquire about the advantages of immediate or deferred Medicare enrollment.

For employees and their enrolled spouses age 65 and older, the PEBB medical plan will provide primary insurance coverage, and Medicare coverage will be secondary. However, employees age 65 and older may choose to reject his or her PEBB medical plan and choose Medicare as their primary insurer. If an employee does so, the employee cannot enroll in a PEBB medical plan. The employee can again enroll in a PEBB medical plan during a special open enrollment or annual open enrollment. However, the employee may remain enrolled in PEBB dental, life and long-term disability insurance coverage.

In most situations, employees and their spouses can elect to defer Medicare Part B enrollment, without penalty, up to the date the employee terminates employment or retires. If Medicare entitlement is due to disability, the enrollee must contact Medicare about deferral of premiums. Upon retirement, Medicare will become the primary insurance, and the PEBB medical plan becomes secondary.

Medicare guidelines direct that qualified/Washington State-registered domestic partners who are age 65 or older must have Medicare as their primary insurer.

When Medical Enrollment Ends

TIP: If your coverage under this plan ends, you must pay the costs of any services or supplies, except when coverage is required by law.

Medical plan enrollment ends on the following dates:

1. At midnight on the last day of the month when any individual ceases to be eligible for PEBB insurance coverage.
2. On the date a plan terminates, if that should occur. Any person losing coverage will be given the opportunity to enroll in another PEBB medical plan.

Premium payments are not prorated if an enrollee dies or cancels his or her medical plan before the end of the month.

If an enrollee or newborn eligible for benefits under "Obstetric and Newborn Care" is confined in a hospital or skilled nursing facility for which benefits are provided when PEBB medical coverage ends and the enrollee is not immediately covered by other health plan coverage, employer contribution to insurance coverage will be extended until whichever of the following occurs first:

- The enrollee is discharged from the hospital or from a hospital to which the enrollee is directly transferred;
- The enrollee is discharged from a skilled nursing facility when directly transferred from a hospital when the skilled nursing facility confinement is in lieu of hospitalization;
- The enrollee is discharged from the skilled nursing facility or from a skilled nursing facility to which the enrollee is directly transferred;
- The enrollee is covered by another health plan that will provide benefits for the services; or
- Benefits are exhausted.

When medical plan enrollment ends, the enrollee may be eligible for continuation of coverage or conversion to other health plan coverage if application is made within the timelines explained in the following sections.

The enrollee is responsible for timely payment of premiums. If the enrollee's insurance coverage is canceled due to lack of payment, the enrollee's eligibility to participate in PEBB benefits will end.

If you need help getting the correct form for an enrollment or benefit change please call PEBB Customer Service at 1-800-200-1004 or download the form at **www.pebb.hca.wa.gov**.

TIP: When your coverage under this plan ends, you are responsible for letting your providers know when you receive services. If you do not tell your provider your enrollment has ended and he or she bills the plan for services you receive, the plan will deny all claims.

Options for Continuing PEBB Benefits

Employees and their dependents covered by this health plan have options for continuing insurance coverage during temporary or permanent loss of eligibility. There are four possible continuation coverage options for PEBB health plan enrollees:

1. COBRA
2. PEBB Extension of Coverage
3. Leave Without Pay (LWOP) Coverage
4. PEBB retiree insurance coverage

The first three options temporarily extend group insurance coverage in some cases when the subscriber or dependent's PEBB medical plan and dental plan coverage ends. COBRA continuation coverage is governed by eligibility and administrative requirements in

federal law and regulation. PEBB Extension of Coverage is an alternative created for PEBB enrollees who are not eligible for COBRA. LWOP coverage is an alternative in specific situations.

The fourth option above is only available to individuals who meet eligibility and procedural requirements defined in WAC 182-12-171 or surviving dependents who meet eligibility requirements defined in WAC 182-12-250 or 182-12-265. These rules can be found at **www.pebb.hca.wa.gov** in the PEBB Rules and Policies section of the website.

All four options are administered by the PEBB Program. Refer to the *PEBB Continuation of Coverage Election Notice* booklet or the *PEBB Retiree Enrollment Guide* for specific details or call PEBB Customer Service at 1-800-200-1004.

Employees also have the right of conversion to individual medical insurance coverage when continuation of group medical insurance coverage is no longer possible. The employee's dependents also have options for continuing insurance coverage for themselves after losing eligibility.

Family and Medical Leave Act of 1993

Employees on approved leave under the federal Family and Medical Leave Act (FMLA) may continue to receive up to 26 weeks of employer-paid medical, dental, basic life, and basic long-term disability insurance. The employee's employing agency is responsible for determining if the employee is eligible for leave and the duration of the leave under FMLA. The employee must continue to pay the employee premium contribution during this period to maintain eligibility. After that, insurance coverage may be continued as explained in the section titled "Options for Continuing PEBB Benefits."

Payment of Premium During a Labor Dispute

Any employee or dependent whose monthly premiums are paid in full or in part by the employer may pay premiums directly to UMP Classic or the HCA if the employee's compensation is suspended or canceled directly or indirectly as a result of a strike, lockout, or any other labor dispute for a period not to exceed six months.

While the employee's compensation is suspended or canceled, the employee shall be notified immediately by the HCA by mail addressed to the last address of record with the HCA, that the employee may pay premiums as they become due as provided in this section.

Conversion of Coverage

Enrollees have the right to switch from PEBB group medical coverage to an individual conversion plan offered through Regence BlueShield to UMP Classic members when they are no longer able to continue PEBB group coverage, or are not eligible for Medicare or other group coverage that provides benefits for hospital or medical care. Enrollees must apply for conversion coverage no later than 31 days after their group coverage ends.

Evidence of insurability (proof of good health) is not required to obtain the conversion coverage. The rates, coverage and eligibility requirements of our conversion program differ from those of the enrollee's current group medical plan. Enrollment in a conversion plan may limit the enrollee's ability to later purchase an individual plan without health screening or a preexisting condition waiting period. To receive detailed information on conversion options under this plan, call Customer Service at 1-888-849-3681.

Appeals of Determinations of PEBB Eligibility

Any employee or employee's dependent may appeal a decision about PEBB eligibility. Guidance on filing an appeal can be found in chapter 182-16 WAC (which governs PEBB appeals), and at **www.pebb.hca.wa.gov**.

Relationship to Law and Regulations

The language of this Certificate of Coverage (COC) is based on the rules that administer the Health Care Authority's PEBB Program in chapters 182-08, 182-12, 182-16 WAC. In the case of a conflict between the rules and the language describing eligibility and enrollment in this COC, the rules shall govern. This agreement between the HCA and the contracted vendor for benefits shall be interpreted, administered, and enforced according to the laws and regulations of the state of Washington, except as preempted by federal law.

Eligibility and Enrollment for Retirees and Surviving Dependents

Eligibility

Eligibility for Public Employees Benefits Board (PEBB) benefits is based on rules in Washington Administrative Code (WAC) chapters 182-08 and 182-12. These rules can be found at **www.pebb.hca.wa.gov** in the PEBB Rules and Policies section of the website.

Eligible Retirees

Retired or permanently disabled employees, (referred to in the Eligibility and Enrollment sections as "retirees," "subscribers" or "enrollees") of state government, higher education, K-12 school districts, educational service districts and participating employer groups are eligible for enrollment in Public Employees Benefits Board (PEBB) medical plans as stated in PEBB rules in WAC 182-12-171. Employees will lose their right to enroll in PEBB retiree insurance coverage if they do not apply to enroll or defer enrollment within the time limits described in PEBB rules.

Eligible Surviving Dependents

Eligible widows, widowers, and surviving dependent children (referred to in this book as "surviving dependents," "subscribers" or "enrollees") can enroll in a PEBB medical plan as stated in PEBB rules in chapters 182-08 and 182-12 WAC. Surviving dependents will lose their right to enroll in PEBB retiree insurance coverage if they do not apply to enroll or defer enrollment within the time limits described in PEBB rules. Eligibility criteria for surviving dependents of an eligible employee or an eligible retiree are outlined in WAC 182-12-265. Eligibility criteria for surviving dependents of emergency service personnel who are killed in the line of duty are outlined in WAC 182-12-250.

Retirees, surviving dependents, and their enrolled dependents, are required to enroll in Medicare Part A and Part B if entitled. Enrollees who are entitled to Medicare must enroll in Medicare Part A and Part B as required by PEBB rules. This is a condition of their enrollment. A copy of the enrollee's Medicare card must be provided to the PEBB Program as proof of enrollment in Medicare Part A and Part B. If an enrollee is not entitled to either Medicare Part A or Part B on their 65th birthday, the enrollee must provide the PEBB Program with a copy of the appropriate documentation from the Social Security Administration. The only exception to this rule is for employees who retired before July 1, 1991.

Eligible Dependents

To be enrolled in a medical plan, a dependent must be eligible under WAC 182-12-260 and the subscriber must follow the enrollment requirements outlined in WAC 182-12-262.

The PEBB Program verifies the eligibility of all dependents and reserves the right to request documents from subscribers that prove a dependent's eligibility. The PEBB Program will remove a subscriber's enrolled dependents from health plan enrollment if the PEBB Program is unable to verify a dependent's

eligibility. The PEBB Program will not enroll or reenroll dependents into a health plan if the PEBB Program is unable to verify a dependent's eligibility.

The following are eligible as dependents under the PEBB eligibility rules:

1. Lawful spouse.
2. Effective January 1, 2010, Washington State-registered domestic partners, as defined in RCW 26.60.020(1).
3. Children. Children are defined as the subscriber's biological children, stepchildren, legally adopted children, children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child, children of the subscriber's Washington State-registered domestic partner, or children specified in a court order or divorce decree.

   In addition, children include extended dependents in the legal custody or legal guardianship of the subscriber, the subscriber's spouse, or subscriber's Washington State-registered domestic partner. The legal responsibility is demonstrated by a valid court order and the child's official residence with the custodian or guardian. "Children" does not include foster children for whom support payments are made to the subscriber through the state Department of Social and Health Services foster care program.

   Eligible children include:

   a. Children up to age 26.
   b. Effective January 1, 2011, children of any age with disabilities, mental illness, or intellectual or other developmental disabilities who are incapable of self-support, provided such condition occurs before age 26. Also note:
      - The subscriber must provide evidence of the disability and evidence that the condition occurred before age 26.
      - The subscriber must notify the PEBB Program, in writing, no later than 60 days after the date that a child age 26 or older no longer qualifies under this eligibility. For example, children with a disability who become self-supporting are not eligible as of the last day of the month in which they become capable of self-support.
      - Children age 26 and older who become capable of self-support do not regain eligibility under these criteria if they later become incapable of self-support.
      - The PEBB Program will certify the eligibility of children with disabilities periodically.

ALERT! Notify the PEBB Benefits Services Program at 1-800-200-1004 as soon as possible of changes in dependent status. You may be required to pay for services received by ineligible dependents.

4. Parents.
   a. Parents covered under a PEBB medical plan before July 1, 1990, may continue enrollment on a self-pay basis as long as all of the following are met:
      - The parent maintains continuous enrollment in a PEBB medical plan;
      - The parent qualifies under the Internal Revenue Code as a dependent of the subscriber;
      - The subscriber continues enrollment in PEBB insurance coverage; and
      - The parent is not covered by any other group medical plan.
   b. Parents eligible under this subsection may be enrolled with a different medical plan than that selected by the subscriber. Parents may not enroll additional dependents to their insurance coverage.

Enrollment

PEBB enrollment rules are described in chapters 182-08 and 182-12 WAC. These rules can be found at **www.pebb.hca.wa.gov** in the PEBB Rules and Policies section of the website.

Retiring or permanently disabled employees must meet the procedural and eligibility requirements in WAC 182-12-171. Employees who do not enroll in a PEBB medical plan at retirement are only eligible to enroll later if they have deferred enrollment as stated in WAC 182-12-200 or WAC 182-12-205 and maintained employer-sponsored comprehensive coverage as defined in WAC 182-12-109.

Surviving dependents must meet the applicable procedural and eligibility requirements in WAC 182-12-250 or WAC 182-12-265. Surviving dependents who do not enroll in a PEBB medical plan as described in WAC 182-12-250 or WAC 182-12-265 are only eligible to enroll later date they have deferred health plan enrollment as stated in WAC 182-12-250 and WAC 182-12-265.

An enrollee can enroll in only one PEBB medical plan even if eligibility criteria are met under two or more subscribers.

Deferring Enrollment in PEBB Retiree Coverage

To defer enrollment, the retiree or surviving dependent must submit a PEBB enrollment/change form to the PEBB Program indicating his or her desire to defer enrolling in a PEBB medical plan within the PEBB Program's required enrollment time limits. If a retiree or surviving dependent defers enrollment in a PEBB retiree medical plan, enrollment must also be deferred for PEBB dental.

How to Enroll

Retirees and surviving dependents must submit the appropriate form(s) to enroll in or defer enrollment in PEBB retiree insurance coverage within the time limits described in PEBB rules. If a retiree or surviving dependent(s) cancels his or her PEBB retiree insurance coverage, they are not eligible to enroll at a later date unless they deferred their enrollment.

If a subscriber wants to enroll his or her eligible dependent(s) when the subscriber is first eligible to enroll in PEBB retiree insurance coverage, the subscriber must include the dependent's enrollment information on his or her enrollment form within the relevant time limits described in WAC 182-12-171 or WAC 182-12-250. In addition, the subscriber must provide the required document(s) as evidence of the dependent's eligibility.

A subscriber may enroll his or her dependents during the annual open enrollment (see Annual Open Enrollment section below) or during a special open enrollment (see Special Open Enrollment section below), if the change in enrollment corresponds to the event that creates the special open enrollment for either the subscriber or the subscriber's dependent or both. The subscriber must provide evidence of the event that created the special open enrollment.

When Medical Enrollment Begins

For eligible employees enrolling in a PEBB health plan within 60 days of their employer-paid or COBRA coverage ending, coverage begins on the first day of the month following the loss of other coverage.

For eligible retirees who are enrolling in a PEBB health plan following deferment, medical coverage begins as outlined in WAC 182-12-200 and WAC 182-12-205.

For eligible surviving dependents, medical coverage begins as outlined in WAC 182-12-250 or WAC 182-12-265.

For a retiree's or surviving dependent's eligible dependent, enrolled when the retiree or surviving dependent is newly eligible, medical plan enrollment will begin when the retiree's or surviving dependent's enrollment begins if the retiree or surviving dependent lists his or her dependent on the enrollment form and the dependent meets PEBB eligibility criteria and follows the enrollment requirements.

For a retiree's or surviving dependent's dependent enrolled during the annual open enrollment, medical coverage will begin on January 1 of the following year.

For a retiree's or surviving dependent's dependent enrolled during a special open enrollment, medical coverage will begin the first of the month following the later of the event date or the date the form is received.

Exceptions:

- If adding a child due to birth or adoption (or subscriber assuming a legal obligation for total or partial support in anticipation of adoption), medical coverage will begin on the day the child is born or adopted (or subscriber assuming a legal obligation for total or partial support in anticipation of adoption).
- If adding a child who becomes eligible as an extended dependent through legal custody or legal guardianship, or a child who becomes eligible as a dependent with a disability, medical coverage will begin on the first day of the month following eligibility certification.

ALERT! See "Adding a New Dependent to Your Coverage" on page 25.

Removing Dependents

Retirees and surviving dependents are required to notify the PEBB Program to remove dependents no later than 60 days from the date the dependent no longer meets the eligibility criteria described under Eligible Dependents (WAC 182-12-260). Consequences for not submitting notice within 60 days may include, but are not limited to:

- The dependent may lose eligibility to continue health plan coverage under one of the continuation coverage options described in WAC 182-12-170;
- The subscriber may be billed for claims paid by the health plan for services that were rendered after the dependent lost eligibility;
- The subscriber may not be able to recover subscriber-paid insurance premiums for dependents that lost their eligibility; and
- The subscriber may be responsible for premiums paid by the state for the dependent's health plan coverage after the dependent lost eligibility.

TIP: Retirees should notify PEBB Customer Service at 1-800-200-1004 of address, name, or other changes as soon as possible. This helps ensure that you receive important information about your UMP Classic benefits and helps us serve you better.

Enrollment Following Deferral

Retirees or surviving dependents who defer enrollment may enroll in a PEBB medical plan during the annual open enrollment or no later than 60 days after the date their enrollment in employer-sponsored medical coverage ends as long as they were continuously enrolled in other comprehensive employer-sponsored medical.

Retirees or surviving dependents who defer enrollment while enrolled in a federal retiree

plan as a retiree or dependent will have a one-time opportunity to enroll in a PEBB medical plan during the annual open enrollment or no later than 60 days after their enrollment in a medical plan under the federal retiree plan ends as long as they were continuously enrolled in a medical plan.

Retirees or surviving dependents who defer enrollment while covered under a Medicaid program that provides creditable coverage may enroll in a PEBB medical plan during the annual open enrollment or as described in WAC 182-12-205.

To enroll in a PEBB medical plan, the retiree or surviving dependent must send the appropriate enrollment form(s) and evidence of their continuous enrollment as required in chapter 182-12 WAC to the PEBB Program before the end of the annual open enrollment or no later than 60 days after the date their employer-sponsored, federal retiree plan or Medicaid coverage ends.

Retirees and surviving dependents should contact the PEBB Program to obtain the appropriate forms, information on premiums and available medical plans.

Annual Open Enrollment

Subscribers may make changes to their enrollment during any PEBB annual open enrollment as long as the change is submitted before the end of the annual open enrollment period.

Subscribers may make a change to their enrollment as follows:

- Enroll or remove eligible dependents
- Change medical plan choice

Subscribers must submit the appropriate change form to the PEBB Program. Change forms must be submitted no later than the end of the annual open enrollment (usually November 30). The enrollment change will become effective January 1 of the following year.

Special Open Enrollment

TIP: You may be eligible to change medical plans if you move during the calendar year. See pages 93–94 for a list of special open enrollment events.

Subscribers may change their enrollment outside of the annual open enrollment if a special open enrollment event occurs. However, the change in enrollment must correspond to the event that creates the special open enrollment for either the subscriber or the subscriber's dependent (or both).

Exception: A retiree or surviving dependent may cancel a dependent's enrollment at any time. Retirees or surviving dependents who have deferred their PEBB retiree insurance coverage may only enroll as described in the "Enrollment Following Deferral" section.

To make an enrollment change, the subscriber must submit the appropriate form(s) to the PEBB Program no later than 60 days after the event that created the special open enrollment. In addition to the appropriate forms, the PEBB Program may require the subscriber to prove eligibility or provide evidence of the event that created the special open enrollment.

Exception: If a subscriber wants to enroll a newborn or child whom the subscriber has adopted or has assumed a legal obligation for total or partial support in anticipation of adoption, the subscriber should notify the PEBB Program by submitting an enrollment form as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the subscriber **must** submit the appropriate enrollment form no later than 12 months after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption.

An eligible qualifying event must occur to create a special open enrollment that allows a subscriber to:

- Change his or her health plan, or
- Enroll or remove eligible dependents

When can a subscriber change his or her health plan?

Any one of the following events may create a special open enrollment:

1. Subscriber acquires a new dependent due to:
   a. Marriage or registering a domestic partnership with Washington's Secretary of State,
   b. Birth, adoption or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption,
   c. A child becoming eligible as an extended dependent through legal custody or legal guardianship, or
   d. A child becoming eligible as a dependent with a disability.
2. Subscriber or a subscriber's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);
3. Subscriber or a subscriber's dependent has a change in employment status that affects the subscriber's or a subscriber's dependent's eligibility for the employer contribution toward group health coverage;
4. Subscriber or a subscriber's dependent has a change in residence that affects health plan availability. If the subscriber moves and the subscriber's current health plan is not available in the new location the subscriber must select a new health plan. If the subscriber does not select a new health plan, the PEBB Program may change the subscribers health plan as described in WAC 182-08-196;
5. Subscriber receives a court order or medical support order requiring the subscriber, the subscriber's spouse, or the subscriber's Washington State-registered domestic partner to provide insurance coverage for an eligible dependent (a former spouse or former registered domestic partner is not an eligible dependent);
6. Subscriber or a subscriber's dependent becomes eligible for state premium assistance through Medicaid or a state children's health insurance program (CHIP), or the subscriber or dependent loses eligibility under Medicaid or CHIP;
7. Subscriber or subscriber's dependent becomes entitled to Medicare, enrolls in or disenrolls from a Medicare Part D plan. If the subscriber's current health plan becomes unavailable due to the subscriber's or a subscriber's dependent's entitlement to Medicare the subscriber must select a new health plan as described in WAC 182-08-196;
8. Subscriber or a subscriber's dependent's current health plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account (HSA). The PEBB Program may require evidence that the subscriber or subscriber's dependent is no longer eligible for an HSA;
9. Subscriber experiences a disruption that could function as a reduction in benefits for the subscriber or the subscriber's dependent(s) due to a specific condition or ongoing course of treatment. A subscriber may not change their health plan if the subscriber's or an enrolled dependent's physician stops participation with the subscriber's health plan unless the PEBB

Program determines that a continuity of care issue exists. The PEBB Program criteria used will include, but is not limited to, the following:

a. Active cancer treatment; or
b. Recent transplant (within the last 12 months); or
c. Scheduled surgery within the next 60 days; or
d. Major surgery within the previous 60 days; or
e. Third trimester of pregnancy; or
f. Language barrier.

ALERT! If an enrollee's provider or health care facility discontinues participation with this plan, the enrollee may not change medical plans until the next open enrollment period, unless the PEBB Appeals Manager determines that a continuity of care issue exists (for additional detail see WAC 182-08-198). The plan cannot guarantee that any one physician, hospital, or other provider will be available or remain under contract with us.

When can a subscriber enroll or remove eligible dependents?

Any one of the following events may create a special open enrollment:

1. Subscriber acquires a new dependent due to:
   a. Marriage or registering a domestic partnership with Washington's secretary of state;
   b. Birth, adoption, or when a subscriber has assumed a legal obligation for total or partial support in anticipation of adoption;
   c. A child becoming eligible as an extended dependent through legal custody or legal guardianship; or
   d. A child becoming eligible as a dependent with a disability.
2. Subscriber or a subscriber's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);
3. Subscriber or a subscriber's dependent has a change in employment status that affects the subscriber's or the subscriber's dependent's eligibility for the employer contribution toward group health coverage;
4. Subscriber receives a court order or medical support order requiring the subscriber, the subscriber's spouse, or the subscriber's Washington State-registered domestic partner to provide insurance coverage for an eligible dependent. (A former spouse or former registered domestic partner is not an eligible dependent.);
5. Subscriber or a subscriber's dependent becomes eligible for state premium assistance through Medicaid or a state children's health insurance program (CHIP), or the subscriber or dependent loses eligibility under Medicaid or CHIP.

Medicare Entitlement

Medicare Part A and Medicare Part B

If an enrollee becomes entitled to Medicare, he or she should contact the nearest Social Security Administration Office to inquire about Medicare enrollment. Unless retirement occurred before July 1, 1991, or the enrollee is a dependent of an employee who retired before July 1, 1991 and is enrolled in PEBB coverage, the enrollee must enroll in Medicare Part A and Medicare Part B in order to continue PEBB retiree insurance coverage. Medicare will become the primary insurance coverage, in most cases, and the PEBB retiree medical plan will become the secondary insurance coverage.

PEBB rules do not require you to enroll in Medicare's prescription drug coverage, Medicare Part D. You cannot have both UMP Classic and Medicare Part D. If you drop your UMP Classic coverage and sign up for Medicare Part D, you will need to select a Medicare supplement plan offered through PEBB. If you do not sign up with a PEBB Medicare supplement plan, you won't be able to come back to a PEBB plan in the future.

Medicare Part D

PEBB has determined that UMP Classic has prescription drug coverage that is, on average, as good as or better than the standard Medicare Part D prescription drug coverage (it is "creditable coverage"). Therefore, you cannot enroll in Medicare Part D and remain in UMP Classic. If you choose to enroll in Medicare Part D, you may continue your PEBB coverage only by enrolling in the PEBB-sponsored Medicare Supplement Plan.

PEBB sends out a "certificate of creditable prescription drug coverage" each year. If sometime in the future you or your covered family member(s) decide to drop your UMP Classic coverage, you will need to show this as proof that you had "creditable coverage" if you apply for Part D. If you do not show that you had creditable coverage, you may have to pay higher Medicare premiums.

When Medical Enrollment Ends

TIP: If your coverage under this plan ends, you must pay the costs of any services or supplies, except when coverage is required by law.

Medical plan enrollment ends on the following dates:

1. At midnight on the last day of the month when any individual ceases to be eligible for PEBB insurance.
2. On the date a plan terminates, if that should occur. Any person losing coverage will be given the opportunity to enroll in another PEBB medical plan.
3. For an enrollee who declines the opportunity or is ineligible to continue enrollment in a PEBB medical plan under one of the options for continuing PEBB benefits described in this certificate of coverage, coverage ends for the enrollee at midnight on the last day of the month in which he or she ceases to be eligible under PEBB rules (such as a spouse when a final decree of divorce is entered).
4. If the subscriber stops paying monthly premiums, coverage ends for the subscriber and enrolled dependents on the last day of the month for which the last full premium was paid. A full month premium is charged for each calendar month of coverage.

Premium payments are not prorated if an enrollee dies or cancels his or her medical plan before the end of the month.

If an enrollee, or newborn eligible for benefits under "Obstetric and Newborn Care," is confined in a hospital or skilled nursing facility for which benefits are provided when PEBB coverage ends and the enrollee is not

immediately covered by other health care coverage, benefits will be extended until whichever of the following occurs first:

- The enrollee is discharged from the hospital or from a hospital to which the enrollee is directly transferred,
- The enrollee is discharged from a skilled nursing facility when directly transferred from a hospital when the nursing facility confinement is in lieu of hospitalization,
- The enrollee is discharged from the skilled nursing facility or from a skilled nursing facility to which the enrollee is directly transferred,
- The enrollee is covered by another health plan that will provide benefits for the services; or
- Benefits are exhausted.

When medical plan enrollment ends, the enrollee may be eligible for continuation of coverage or conversion to other health care coverage if application is made within the time limits explained in the following sections.

The enrollee is responsible for timely payment of premiums and reporting changes in eligibility or address. If the enrollee's account is delinquent, the enrollee's coverage will be canceled retroactive to the end of the month in which the last full premium was received. If the enrollee's coverage is canceled due to lack of payment, the enrollee's eligibility to participate in the PEBB Program will end.

The enrollee and his or her covered dependent(s) or beneficiary is responsible for reporting changes no later than 60 days after the event, such as divorce, termination of a Washington State-registered domestic partnership, death, or when no longer a dependent as defined in WAC 182-12-260.

Failure to report changes can result in loss of premiums and loss of the enrollee and his or her dependent's right to continue coverage under the federal COBRA law or PEBB rules. To obtain the required forms subscribers can contact PEBB Customer Service at 1-800-200-1004.

TIP: If your coverage under this plan ends, you are responsible for letting your providers know when you receive services. If you do not tell your provider your enrollment has ended and he or she bills UMP Classic for services you receive, the plan will deny all claims.

Options for Continuing PEBB Benefits

Subscribers and their dependents covered by this medical plan may be eligible to continue enrollment if they lose eligibility and are eligible under one of the following options for continuing coverage:

1. COBRA gives enrollees the right to continue group coverage for 18 to 36 months. Refer to the Continuation Coverage Election Notice booklet for specific details.
2. PEBB Extension of Coverage allows for continued retiree coverage of dependents of a deceased subscriber.
3. PEBB retiree insurance coverage.

The first two options above temporarily extend group insurance coverage if certain circumstances occur that would otherwise end your or your dependent's PEBB medical plan. COBRA continuation coverage is governed by eligibility and administrative requirements in federal law and regulation. PEBB Extension of Coverage is an alternative created for PEBB enrollees who are not eligible for COBRA.

The third option above is only available to surviving dependents who meet eligibility requirements defined in WAC 182-12-250 or WAC 182-12-265. These rules can be found at **www.pebb.hca.wa.gov** in the PEBB Rules

and Policies section of the website. You may also contact PEBB Customer Service at 1-800-200-1004 or refer to the Continuation of Coverage Election Notice booklet for details.

Retirees and their dependents may also have the right of conversion to an individual medical plan when continuation of group coverage is no longer possible.

Conversion of Coverage

Enrollees have the right to switch from PEBB group medical coverage to an individual conversion plan offered through Regence BlueShield to UMP Classic members when they are no longer able to continue PEBB group coverage, or are not eligible for Medicare or other group coverage that provides benefits for hospital or medical care. Enrollees must apply for conversion coverage no later than 31 days after their group coverage ends.

Evidence of insurability (proof of good health) is not required to obtain the conversion coverage. The rates, coverage and eligibility requirements of our conversion program differ from those of the enrollee's current group plan. Enrollment in a conversion plan may limit the enrollee's ability to later purchase an individual plan without health screening or a preexisting condition waiting period. To receive detailed information on conversion options under this plan, call Customer Service at 1-888-849-3681.

Appeals of Determinations of PEBB Eligibility

Any retiree, surviving dependent or dependent may appeal a decision about PEBB eligibility. Guidance on filing an appeal is in chapter 182-16 WAC (which governs PEBB appeals) and at **www.pebb.hca.wa.gov.**

Relationship to Law and Regulations

The language of this Certificate of Coverage (COC) is based on the rules that administer the Health Care Authority's PEBB Program in Chapters 182-08, 182-12, 182-16 WAC. In the case of a conflict between the rules and the language describing eligibility and enrollment in this COC, the rules shall govern. This agreement between the Health Care Authority and the contracted vendor for benefits shall be interpreted, administered, and enforced according to the laws and regulations of the State of Washington, except as preempted by federal law.

Customer Service

If you have questions about your PEBB retiree eligibility and benefit information, please contact the PEBB Program at 1-800-200-1004 or at **www.pebb.hca.wa.gov.** For questions about Medicare, please contact the Center for Medicare and Medicaid Services (CMS) at 1-800-MEDICARE or go to **www.medicare.gov.**

General Provisions

Relationship to Blue Cross and Blue Shield Association

The Washington State Health Care Authority (HCA) on behalf of itself and you expressly acknowledges its understanding that the agreement constitutes an agreement solely between the HCA and Regence BlueShield, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans (the association), permitting Regence BlueShield to use the Blue Cross and Blue Shield service marks in the state of Washington, for those counties designated in the service area, and that Regence BlueShield is not contracting as the agent of the association. The HCA on behalf of itself and you further acknowledges and agrees that it has not entered into this agreement based upon representations by an person or entity other than Regence BlueShield and that no person or entity other than Regence BlueShield will be held accountable or liable to HCA or you for any of Regence BlueShield's obligations to the HCA or you created under this agreement. This paragraph will not create any additional obligations whatsoever on the part of Regence BlueShield other than those obligations created under other provisions of the agreement.

Out-of-Area Services

Regence BlueShield has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain health care services outside of Regence's service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between Regence and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside the Regence's service area, you will obtain care from health care providers that have a contractual agreement with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from non-network providers. Regence's payment practices in both instances are described below.

BlueCard Program

Under the BlueCard Program, when you access covered services within the geographic area served by a Host Blue, Regence will remain responsible for fulfilling contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its network providers.

Whenever you access covered services outside Regence's service area and the claim is processed through the BlueCard Program, the amount you pay for covered services is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to Regence.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your health care provider. Sometimes, it is an estimated price that takes

into account special arrangements with your health care provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Regence uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, Regence would then calculate your liability for any covered services according to applicable law.

Negotiated National Account Arrangements

As an alternative to the BlueCard Program, your claims for covered services may be processed through a negotiated National Account arrangement with a Host Blue.

The amount you pay for covered services under this arrangement will be calculated based on the lower of either billed covered charges or negotiated price (refer to the description of negotiated price above) made available to Regence by the Host Blue.

Non-Network Providers Outside Regence's Service Area

- **Member Liability Calculation.** When covered services are provided outside of Regence's Service Area by non-network providers, the amount you pay for such services will generally be based on either the Host Blue's non-network provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-network provider bills and the payment Regence will make for the covered services as set forth in this paragraph.
- **Exceptions.** In certain situations, Regence may use other payment bases, such as billed covered charges, the payment Regence would make if the health care services had been obtained within Regence's service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount Regence will pay for services rendered by non-network providers. In these situations, you may be liable for the difference between the amount that the non-network provider bills and the payment Regence will make for the covered services as set forth in this paragraph.

Right to Receive and Release Needed Information

Regence may need certain facts about your health care coverage or services provided in order to process your claims correctly. Regence may get these facts from or give them to other organizations or persons without your consent. You must give Regence any facts necessary for processing of claims to get benefits under UMP Classic.

Right of Recovery

UMP Classic has the right to a refund of incorrect payments. UMP Classic may recover excess payment from any:

- Person that received an excess payment.
- Person on whose behalf an excess payment was made.
- Other issuers of payment.
- Other plans involved.

Limitations on Liability

In all cases, you have the exclusive right to choose a health care provider. Since neither the Uniform Medical Plan (the plan) nor Regence BlueShield provides any health care services, neither can be held liable for any claim or damages connected with injuries you may suffer while receiving health services or supplies provided by professionals who are neither employees nor agents of the plan and Regence BlueShield. Neither Regence BlueShield nor the plan is responsible for the quality of health care you receive, except as provided by law.

In addition, Regence BlueShield will not be liable to any person or entity for the inability or failure to procure or provide the benefits of the plan by reason of epidemic, disaster or other cause or condition beyond Regence BlueShield's control.

Governing Law and Discretionary Language

The Uniform Medical Plan (the plan) will be governed by and construed in accordance with the laws of the United States of America and by applicable laws of the state of Washington without regard to its conflict of law rules. The Washington State Health Care Authority delegates discretion to Regence BlueShield for the purposes of paying benefits under this coverage only if it is determined that you are entitled to them and of interpreting the terms and conditions of the plan. Final determinations pursuant to this reservation of discretion do not prohibit or prevent a claimant from seeking judicial review of those determinations in federal court. The reservation of discretion made under this provision only establishes the scope of review that a court will apply when you seek judicial review of a determination of the entitlement to and payment of benefits or interpretation of the terms and conditions applicable to the plan. Regence BlueShield is not the plan administrator, but does provide claims administration under the plan, and the court will determine the level of discretion that it will accord determinations.

No Waiver

The failure or refusal of either party to demand strict performance of the plan or to enforce any provision will not act as or be construed as a waiver of that party's right to later demand its performance or to enforce that provision. No provision of the plan will be considered waived unless such waiver is reduced to writing and signed by one of the Washington State Health Care Authority's authorized officers.

Definitions

Allowed Amount, Medical Services

Allowed amount is the most the plan pays for a specific covered service or supply. The allowed amount is determined as follows:

- **For network providers** that are within the Regence service area and are not hospitals, the preferred provider organization contract with Regence BlueShield is the relevant contract that determines the allowed amount.
- **For network providers** that are outside the Regence Service Area and are not hospitals, the contract with another Blue Cross or Blue Shield organization in the BlueCard® program for its "Preferred Provider Organization ('PPO') network" is the relevant contract that determines the allowed amount.
- **For network hospitals** located in the Regence service area, Clark County, in Washington, or the Idaho counties of Latah or Nez Perce, a hospital contract with the Washington State Health Care Authority (HCA) is the relevant contract that determines the allowed amount.
- **For network hospitals** outside the Regence Service Area, Clark County, in Washington, and the Idaho counties of Latah and Nez Perce, the contract with another BlueCross or Blue Shield organization in the BlueCard® program for its "Preferred Provider Organization ('PPO') network" is the relevant contract that determines the allowed amount.
- **For non-network providers** (see definition on page 110) within the Regence service area, the amount Regence has determined to be reasonable charges for covered services and supplies.

The allowed amount may be based upon the billed charges for some services, as determined by Regence or as otherwise required by law. Where, although it does not qualify as a network provider hereunder, one of these providers has a contract with Regence, the provider will accept the allowed amount as payment in full.

- **For non-network providers** (see definition on page 110) accessed through the BlueCard Program, the allowed amount is the lower of the provider's billed charges and the amount that the other Blue plan identifies as the amount on which it would base a payment to that provider.

Under the BlueCard Program, when you access covered cervices within the geographic area served by a Host Blue, Regence will remain responsible for fulfilling contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its network providers.

Whenever you access covered services outside Regence's service area and the claim is processed through the BlueCard Program, the amount you pay for covered services is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to Regence.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your health care provider. Sometimes, it is an estimated price that takes into account special arrangements with your health care provider or provider group that may include types of settlements, incentive

payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Regence uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, Regence would then calculate your liability for any covered services according to applicable law.

Charges in excess of the allowed amount are not reimbursable. For questions regarding the basis for determination of the allowed amount, please call Customer Service at 1-888-849-3681 (TTY 711).

Allowed Amount, Prescription Drugs

The **allowed amount for prescription** drugs is based on Washington State Rx Services' contractually agreed reimbursement, unless other contractual arrangements or terms apply. All covered prescription drug claims are paid based on this allowed amount.

Ambulatory Surgery Center (ASC)

An **ambulatory surgery center** (ASC) is a health care facility that specializes in providing surgery, pain management, and certain diagnostic services in an outpatient setting. ASC-qualified procedures are typically more complex than those done in a doctor's office but not so complex as to require an overnight stay. Procedures commonly performed in these centers include colonoscopies, endoscopies, cataract surgery, orthopedic, and ENT (ear, nose, and throat) procedures. An ASC may also be known as an outpatient surgery center or same-day surgery center.

Ancillary Charge

The **ancillary charge** applies to Tier 3 non-preferred drugs that have a generic equivalent (see page 105). The plan pays as if you had purchased the Tier 1 generic drug and you pay the rest of the cost. Specifically, you pay the Tier 1 coinsurance ***plus*** the difference in cost between the generic and the brand-name drugs. **NOTE:** This amount does not apply to either your prescription drug deductible or medical out-of-pocket limit.

Appeal

See pages 69–74 for an explanation of appeals and how the process works.

Authorized Representative

In most cases, UMP Classic must have written authorization to communicate with anyone but the enrollee (patient) except when the enrollee is under age 13: a parent or legal guardian may act as representative. Under some circumstances, written authorization is necessary when the enrollee is age 13 to 17.

You may choose to authorize a representative to:

- Talk to UMP Classic about claims or services.
- Share your protected health information.
- Handle an appeal on your behalf.

To designate an authorized representative, you must complete an *Authorization to Disclose Protected Health Information* form, available by calling Customer Service at 1-888-849-3681 or through **www.myRegence.com**. Send the form to the address on the form. UMP Classic

cannot share information or proceed with an appeal until we receive the completed form.

On the form, you must specify:

- What information may be disclosed;
- The purpose of the disclosure (for example, handling an appeal on your behalf); and
- Who is designated to receive or release the information.

Brand-Name Drug

A **brand-name drug** is a drug sold under the proprietary name or trade name selected by the manufacturer.

Calendar Year

A **calendar year** is January 1 through December 31.

Chemical Dependency

Chemical dependency is an illness characterized by a physiological or psychological dependency on a controlled substance or alcohol.

Coinsurance

Coinsurance is the percentage of the allowed amount you must pay the provider on claims for which the plan pays less than 100% of the allowed amount. This includes most medical services and prescription drugs.

Coordination of Benefits

For members covered by more than one health plan, **coordination of benefits** is the method the plan uses to determine which plan pays first, which pays second, and the amount paid by each plan. Please see description and examples in "If You Have Other Medical Coverage" on pages 52–56.

Copayment

Copayment (or copay) is a set dollar amount you pay when receiving specific services, treatments, or supplies, such as inpatient hospitalization or emergency room visits.

Cost Share

Cost share means the amount you pay for a service, supply, or drug. This may be a deductible (page 5), coinsurance (page 6), copay (page 6), or amounts not covered by the plan.

Custodial Care

Custodial care is care primarily to assist in activities of daily living, including institutional care primarily to support self-care and provide room and board. Custodial care includes, but is not limited to, help in walking, getting into and out of bed, bathing, dressing, feeding and preparing special diets, and supervising medications that are ordinarily self-administered.

Deductible

See the definitions of "Medical Deductible" and "Prescription Drug Deductible."

Dependent

A **dependent** is a spouse, qualified or Washington State-registered domestic partner, child, or other family member covered by the plan under the subscriber's account (see "Eligible Dependents" on pages 78–79 and pages 88–89).

Developmental Delay

Developmental delay is a significant lag in reaching developmental milestones as expected during infancy and early childhood. The cause may be present at birth or acquired after birth from a disease or disorder of the body, an injury, a disorder of the mind or emotions, or harmful effects of the surrounding environment. Only a physician or other provider can diagnose a developmental delay.

Domestic Partner

For the purposes of this *Certificate of Coverage*, a **domestic partner** is a person who:

- Is part of a Washington State-registered domestic partnership (see criteria stated in RCW 26.60.30) as of January 1, 2010; **or**
- Was enrolled as a qualified domestic partner in a PEBB health plan before January 1, 2010, and continues to meet the criteria under which he or she was enrolled.

Durable Medical Equipment

Durable medical equipment is:

- Designed for prolonged use.
- For a specific therapeutic or clinical purpose, or to assist in the treatment of an injury or illness.
- Medically necessary (meeting all plan medical necessity criteria).
- Primarily and customarily used only for a medical purpose.

See exclusion 20 on page 48 for examples of durable medical equipment that are not covered.

Emergency

See "Medical Emergency."

Endorsing Prescriber

An **endorsing prescriber** is a provider who has endorsed the Washington Preferred Drug List and has agreed to allow "therapeutic interchange" (see page 39) of a preferred drug for a nonpreferred one in the same drug class.

Enrollee

An **enrollee** is an employee, retiree, former employee, or dependent enrolled in this plan (see also "Member," "Subscriber," and "Dependent").

Experimental or Investigational

Experimental or investigational means a service, supply, or drug that the plan has classified as investigational. The plan will review scientific evidence from well-designed clinical studies found in peer-reviewed medical literature, if available, and information obtained from the treating provider regarding the service, supply, or drug to determine if it is investigational. A service, supply, or drug not meeting all of the following criteria is, in the plan's judgment, investigational if:

- A medication or device, the health intervention must have final approval from the United States Food and Drug Administration as being safe and efficacious for general marketing. However, if a medication is prescribed for other than its FDA-approved use and is recognized as "effective" for the use for which it is being prescribed, benefits for that use will not be excluded. To be considered "effective" for other than its FDA-approved use, a medication must be so recognized in one of the standard reference compendia (see definition on page 114) or, if not, then in a majority of relevant peer-reviewed medical literature (see definition on page 111); or by the United States Secretary of Health and Human Services.
- The scientific evidence must permit conclusions concerning the effect of the service, supply, or drug on health outcomes, which include the disease process, injury or illness, length of life, ability to function, and quality of life.
- The service, supply, or drug must improve net health outcome.
- The scientific evidence must show that the service, supply, or drug is as beneficial as any established alternatives.
- The improvement must be attainable outside the laboratory or clinical research setting.

When the plan receives a claim or request for preauthorization that includes all information necessary to make a decision, you will be informed within 20 business days if the service, supply, or drug is considered experimental or investigational. To determine the necessary documentation, call Customer Service at 1-888-849-3681 (TTY 711). You may have the right to an expedited appeal; see page 71 for that process.

Explanation of Benefits (EOB)

An **Explanation of Benefits** (EOB) is a detailed account of each claim processed by the plan, which is sent to you to notify you of claim payment or denial. You can also get this online at **www.myRegence.com**, or call Customer Service to request a copy of an EOB (you will need to provide identifying information).

Family

Family is defined as all eligible family members (subscriber and dependents) who are enrolled on a single account.

Fee Schedule

A **fee schedule** is a list of the plan's maximum payment amounts for specific services or supplies. Network providers have agreed to accept these fees as payment in full for services to enrollees. See "Allowed Amount, Medical Services" on pages 101–102 for more details.

Formulary

See "What Drugs are Covered? The *UMP Preferred Drug List*" on page 31.

Generic Drug

A **generic drug** is a drug with the same active ingredient(s), but not necessarily the same inactive ingredients, as a brand-name drug that is no longer protected by a commercial patent. A generic drug is therapeutically equivalent to the brand-name drug, which means it works like the brand-name drug in dosage, strength, performance, and use. All generic drugs sold in the United States must be reviewed and approved by the U.S. Food and Drug Administration, and meet the same quality and safety standards as brand-name drugs.

Generic Equivalent

A **generic equivalent** is a generic drug that has the same active ingredients as its brand-name counterpart. For a generic drug to be considered "equivalent," it has to be approved by the FDA as being interchangeable with that brand-name drug. Under Washington State law, the pharmacist is required to dispense a generic equivalent in place of a brand-name drug, unless your provider objects. (See "Can the Pharmacist Substitute One Drug for Another?" on page 39 for how this works.)

Grievance

A **grievance** is also called a complaint; see pages 69–74 for details on how these are handled.

Health Care Authority (HCA)

The **Health Care Authority** is the Washington State agency that administers the Uniform Medical Plan (UMP Classic and the UMP Consumer-Directed Health Plan) in addition to the following health care programs: Basic Health, Prescription Drug Program, Public Employees Benefits Board (PEBB) Program, Medicaid, and Washington Health Program.

Health Intervention

Health intervention is a medication, service, or supply provided to prevent, diagnose, detect, treat, or palliate the following: disease, illness, injury, genetic or congenital anomaly, pregnancy or biological or psychological condition that lies outside the range of normal, age-appropriate human variation; or to maintain or restore functional ability. A health intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it

is being applied. A health intervention is considered to be new if it is not yet in widespread use for the medical condition and the patient indications being considered.

High-Cost Generic Drugs

High-cost generic drugs are generic drugs (see page 105) that the plan covers under Tier 2.

Home Health Agency

A **home health agency** is an agency or organization that provides a program of home health care practicing within the scope of its license as a provider of home health services and is Medicare-certified, accredited by the Joint Commission on Accreditation of Healthcare Organizations, or a network provider.

Hospice

Hospice is services provided by a state-licensed hospice program in the home or in a hospice facility to terminally ill patients. Services include pain relief care and support services that address the needs of terminally ill patients and their families without intent to cure.

Hospital

A **hospital** is an institution accredited under the Hospital Accreditation Program of the Joint Commission on Accreditation of Healthcare Organizations and licensed by the state where it's located. Any exception to this must be approved by the plan.

The term hospital ***does not*** include a convalescent nursing home or institution (or a part of one) that:

- Furnishes primarily domiciliary or custodial care.
- Is operated as a school.
- Is used principally as a convalescent facility, rest facility, nursing facility, or facility for the aged.

Inpatient Copay

The **inpatient copay** is what you pay for inpatient services at a network facility—hospital, skilled nursing, mental health, chemical dependency: $200 per day for facility charges. Employees and retirees not enrolled in Medicare pay up to $600 maximum per calendar year; retirees enrolled in Medicare pay up to a $600 maximum per admission (no annual limit).

The inpatient copay does ***not*** count toward your medical deductible or medical out-of-pocket limit. You must pay this copay even if you have met your medical out-of-pocket limit (unless you have met your maximum annual copay).

NOTE: Professional charges, such as for physicians or lab work, may be billed separately and are not included in this copay.

Inpatient Stay

Inpatient stay: From when you are admitted to a hospital or other medical facility, until you are discharged from that facility.

IRO

Independent Review Organization (see page 73).

Limited Benefit

A **limited benefit** is a benefit that is limited to a certain number of visits or a maximum dollar amount. The limit applies to these benefits even if the provider prescribes additional visits and even if the visits are medically necessary. The plan does not make exceptions to benefit limits.

For benefits limited to a certain number of visits, any visits that are applied to your medical deductible (see pages 5–6) also count against your annual visit or dollar limit. In addition, visits that are paid by another health plan that is primary apply to the plan limit.

For example, if your primary plan applies your first six massage therapy sessions to your medical deductible, you may receive coverage for 10 more sessions in that calendar year, for a total of 16 visits (the visit maximum for massage therapy). **Note:** These limits apply *per enrollee*.

Services are counted against a limited benefit according to the type of service, not the provider type. When a provider practicing within the scope of his/her license provides services coded under a limited benefit (for example, spinal manipulation or physical therapy), those services will be counted against the benefit regardless of the provider type. In addition, if more than one type of limited benefit service is provided during a single visit, the services will count against all of the limited benefits. For example, if both manipulation and physical therapy codes are billed for a visit, that visit will count against both the spinal and extremity manipulation and physical therapy benefits.

Maintenance Therapy

Maintenance therapy is a health intervention after the patient has reached maximum rehabilitation potential or functional level and has shown no significant improvement for one to two weeks, and instruction in the maintenance program has been completed.

Medical

Medical generally refers to all plan benefits and services other than those covered under preventive care and prescription drug benefits (except as the term is used in the eligibility sections of this *Certificate of Coverage*).

Medical Benefit

Medical benefit refers to services subject to the deductible and coinsurance. See pages 5–7 for a description of how this works.

Medical Deductible

The **medical deductible** is a dollar amount you must pay each calendar year for health care expenses before the plan starts covering services. You pay the first $250 per person in medical expenses to your providers ($750 maximum if you have a family of three or more on one account). Only expenses covered by the plan count toward your deductible. For example, if you receive LASIK surgery (see exclusion 23 on page 48), the plan does not apply this payment to your deductible. Some services are exempt from this deductible (see the "Summary of Benefits" on pages 8–13).

The medical and prescription drug deductibles are separate: Medical services do **not** count toward your prescription drug deductible. Prescription drug purchases do **not** count toward your medical deductible. See "Prescription Drug Deductible" on page 33.

Medical Emergency

A **medical emergency** means a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson who has an average knowledge of medicine and health would reasonably expect the absence of immediate medical attention at a hospital emergency room to result in any one of the following:

- Placing the person's health, or with respect to a pregnant female, her health or the health of her unborn child, in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Medically Necessary Services, Supplies, Drugs, or Interventions

ALERT! The provider or patient must provide documentation demonstrating medical necessity when requested by the plan, or services may be denied as not medically necessary.

Medically Necessary or **Medical Necessity** means health care services, supplies, or interventions that a treating licensed health care provider recommends and all of the following conditions are met:

1. The purpose of the service, supply, intervention, or drug is to treat or diagnose a medical condition.
2. It is the appropriate level of service, supply, or intervention, or drug dose considering the potential benefits and harm to the patient.
3. The level of service, supply, intervention, or drug dose is known to be effective in improving health outcomes.
4. The level of service, supply, intervention, or drug recommended for this condition is cost-effective compared to alternative interventions, including no intervention.

The fact that a physician or other provider prescribes, orders, recommends, or approves a service or supply, drug, or drug dose does not, in itself, make it medically necessary.

The plan may require proof that services, interventions, supplies, or drugs, including court-ordered care are medically necessary. No benefits will be provided if the proof isn't received or isn't acceptable, or if the service, supply, drug, or drug dose is not medically necessary. Claims processing may be delayed if proof of medical necessity is required but not provided by the health service provider.

The plan uses scientific evidence from peer-reviewed medical literature to determine effectiveness for services and interventions, not yet in widespread use for the medical condition and patient indications being considered. Under state law, UMP Classic must follow coverage decisions made by the Health Technology Clinical Committee regarding coverage of services or interventions (see page 14). For other services, interventions, or supplies the plan first uses scientific evidence, then professional standards, then expert opinion to determine effectiveness. "Effective" means that the drug, drug dose, intervention, supply, or level of service can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects. The scientific evidence should be considered first and, to the greatest extent possible, should be the basis for determining medical necessity. If no scientific evidence is available, professional standards of care should be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about interventions should be based on expert opinion. Giving priority to scientific evidence does not mean that the plan should deny coverage of interventions in the absence of conclusive scientific evidence. Interventions can meet the plan's definition of medical necessity in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care, or, in the absence of such standards, convincing expert opinion.

A level of service, supply, drug, or intervention is considered "cost effective' if the benefits and harms relative to the costs represent an economically efficient use of resources for the patients with this condition. The plan applies this criterion based on the characteristics of the individual patient. Cost-effective does not necessarily mean the lowest price.

Preventive services not covered by the plan's preventive care benefit will still be covered under the medical benefit if medically necessary.

A "health intervention" is an item or service delivered or undertaken primarily to treat

(that is prevent, diagnose, detect, treat, or palliate) a medical condition (such as a disease, illness, injury, genetic or congenital defect, pregnancy, or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation) or to maintain or restore functional ability. For purposes of this definition of "medical necessity" the plan does not consider a health intervention separately from the medical condition and patient indications it is applied to.

"Treating provider" means a licensed health care provider who has personally evaluated the patient.

"Health outcomes" are results that affect health status as measured by the length or quality (primarily as perceived by the patient) of a person's life.

Scientific evidence consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive, but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases.

Interventions for which clinical trials have not been conducted because of epidemiological reasons (that is, rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care or expert opinion.

Medical Out-of-Pocket Limit

The **medical out-of-pocket limit** is the maximum total amount you pay in coinsurance and copayments for medical services during a calendar year. For more information, see page 7 under "What Is the Medical Out-of-Pocket Limit?"

For prescription drugs, see the prescription cost-limit in the table on page 33.

Member

A **member** is an employee, retiree, former employee, or dependent enrolled in the plan (see also "Enrollee").

Network Provider(s)

A **network professional provider** is a provider:

- In the Regence Service Area and contracted as part of Regence BlueShield's preferred provider organization network; or
- Outside the Regence Service Area and contracted with another Blue Cross or Blue Shield organization in the BlueCard® program (designated as a Provider in the "Preferred Provider Organization ("PPO") Network") to provide services and supplies to plan members.

A **network hospital** is one that is:

- In the Regence Service Area, Clark County in Washington, or the Idaho counties of Latah or Nez Perce and is contracted with the Washington State Health Care Authority; or
- Outside the Regence Service Area and contracted with another Blue Cross or Blue Shield organization in the BlueCard® program (designated as a Provider in the "Preferred Provider Organization ("PPO") Network") to provide services and supplies to plan members.

Network Vaccination Pharmacy

A **network vaccination pharmacy** is a pharmacy that contracts with Washington State Rx Services to give immunizations to plan enrollees at the network rate. You can find out which pharmacies are contracted at **www.ump.hca.wa.gov** or by calling Washington State Rx Services at 1-888-361-1611.

Noncovered Services

Noncovered services refers to any service that is not covered by the plan. Some services may be medically necessary, yet still are not covered. See "What the Plan Doesn't Cover" on pages 47–51 and "Guidelines for Drugs Not Covered" on page 42 for details.

Nonduplication of Benefits

Nonduplication of benefits is how UMP Classic coordinates benefits when UMP Classic is your secondary coverage (see definition on page 114). When another plan (other than Medicare) is primary (pays first), that plan pays their normal benefit. UMP Classic then pays up to the amount we would have paid if UMP Classic had been the primary plan. If the primary plan pays as much or more than the normal UMP Classic benefit, UMP Classic pays nothing. UMP Classic does not pay the rest of the allowed amount.

Example *(this is an example only, and may not apply to your specific situation)*

Plan	Allowed amount	Plan's normal benefit	Paid by plan
Plan A (primary)	$100	$85	$85
UMP Classic (secondary)	$100	$85	0
		You pay:	$15

Non-Network Provider(s)

A **non-network provider** is a health care provider who or that:

- Is not a hospital and is:
  - in the Regence Service Area, but is not contracted as part of Regence BlueShield's preferred provider organization network; or
  - outside the Regence Service Area, but is not contracted with another Blue Cross or Blue Shield organization in the BlueCard® program (designated as a Provider in the "Preferred Provider Organization ("PPO") Network") to provide services and supplies to plan members; or
- Is a hospital in the Regence Service Area, Clark County in Washington , or the Idaho counties of Latah or Nez Perce that is not contracted with the Washington State Health Care Authority (whether or not it is contracted with Regence BlueShield or any Regence BlueShield affiliate); or
- Is a hospital outside the Regence Service Area, Clark County in Washington, and the Idaho counties of Latah and Nez Perce that is not contracted with another Blue Cross or Blue Shield organization in the BlueCard® program (designated as a Provider in the "Preferred Provider Organization ("PPO") Network") to provide services and supplies to plan members.

Nonpreferred Drug

A **nonpreferred drug** is a prescription drug designated as Tier 3 (nonpreferred) in the *UMP Preferred Drug List* (see page 31).

Normal Benefit

The plan's **normal benefit** is the dollar amount of the benefit the plan would normally pay if no other health plan had the primary responsibility to pay the claim.

Occupational Injury or Illness

An **occupational injury or illness** is one resulting from work for pay or profit.

Open Enrollment Period

Open enrollment is a period defined by the HCA when you have the opportunity to change to another health plan offered by the PEBB Program for an effective date beginning January 1 of the following year.

Orthognathic Surgery

Orthognathic surgery is surgery to correct conditions of the jaw and face related to structure, growth, sleep apnea, TMJ disorders, or to correct orthodontic problems that cannot be easily treated with braces.

Out-of-Pocket Limit (Medical)

See definition under "Medical Out-of-Pocket Limit." For more information on how this works, see page 7 under "What Is the Medical Out-of-Pocket Limit?" (See the cost-limit for prescription drugs in the table on page 33.)

Over-the-Counter Alternative

An **over-the-counter alternative** drug is an over-the-counter drug with similar safety, efficacy, and ingredients as a prescription drug.

Over-the-Counter Drugs

Over-the-counter drugs are medications you can get without a prescription.

Over-the-Counter Equivalent

An **over-the-counter equivalent** is an over-the-counter drug that has identical active ingredients and strengths as a prescription drug or product in a comparable dosage form.

P&T Committee

See **"Pharmacy & Therapeutics Committee."**

PEBB

The **Public Employees Benefits Board** is a group of representatives, appointed by the governor, that establishes the terms and conditions of eligibility and benefits for public employees, as defined by Washington State law RCW 41.05.011.

PEBB Plan

A **PEBB plan** is one of several insurance plans, including the Uniform Medical Plan (UMP Classic and the UMP Consumer-Directed Health Plan), offered through the Public Employees Benefits Board (PEBB) Program to public employees, former employees, retirees, and their dependents. Benefits and eligibility are designed by the PEBB and administered by the Health Care Authority (HCA) as part of a comprehensive benefits package.

PEBB Program

The **PEBB Program** is the Washington State Health Care Authority program that administers PEBB benefit eligibility and enrollment.

Peer-Reviewed Medical Literature

Peer-reviewed medical literature is scientific studies printed in journals or other publications in which original manuscripts are published only after being critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. Peer-reviewed medical literature, for example, does not include information from health-related websites or in-house publications of pharmaceutical manufacturers.

Pharmacy & Therapeutics (P&T) Committee

Pharmacy & Therapeutics Committee: A group of providers and other health care professionals that review and determine how prescription drugs are covered (see page 32).

Plan

Plan as referred to in this document means the Uniform Medical Plan Classic (UMP Classic), a self-funded PPO plan offered by the PEBB Program. In the eligibility sections (pages 78–97), "plan" refers to any PEBB-sponsored plan. In the "If You Have Other Medical Coverage" section on pages 52–56, "plan" may mean any health insurance coverage.

Post-Service

Post-Service means any claim for benefits under the plan that is not considered pre-service (see page 113).

PPO

A **Preferred Provider Organization (PPO)** is a health plan that has a network of providers who have agreed to provide services for the plan's enrollees at discounted rates. Enrollees may self-refer to specialists. UMP Classic is a PPO.

Preauthorization

Preauthorization is approval by the plan for coverage of specific services, supplies, or drugs before they are provided to the member. Preauthorization is not a guarantee of coverage. If you or your provider do not receive preauthorization for certain medical services or drugs, the claim may be denied. See "Preauthorization" on pages 44–45 for a list of medical services that require preauthorization, and page 37 for information on drugs that must be preauthorized.

Preferred Drug

A **preferred drug** is a prescription drug that is listed on the *UMP Preferred Drug List* and covered under the Value Tier, Tier 1, or Tier 2. Tier 3 (nonpreferred) drugs are also covered by the plan, but you pay more (see table on page 33).

Preferred Drug List

The ***UMP Preferred Drug List*** is a list available online that specifies how prescription drugs are covered by the plan. By using this list, you can find out if a drug is covered. how much you'll pay, if the drug must be ordered through the plan's specialty drug pharmacy, and whether the drug has any limitations (such as needing preauthorization or quantity limits; see pages 37–40).

Drugs are designated by "tiers": NC means not covered; Value Tier are cost-effective drugs for treatment of certain chronic conditions; Tier 1 are primarily generic drugs; Tier 2 are preferred brand-name drugs and some high-cost generic drugs; and Tier 3 are nonpreferred brand-name drugs.

The *UMP Preferred Drug List* is based on the Washington Preferred Drug List and recommendations by one of the Pharmacy & Therapeutics Committees that partner with Washington State Rx Services (see page 32 for more information).

If your drug is not listed, call Washington State Rx Services at 1-888-361-1611.

Prenatal

Prenatal means during pregnancy.

Prescription Cost-Limit

The most you pay for a generic or preferred prescription drug at a network pharmacy; see page 33 for how this works.

Prescription Drug Deductible

The **prescription drug deductible** is a dollar amount you must pay each calendar year for Tier 2 and Tier 3 prescription drugs before the plan starts paying benefits for these drugs. You pay the first $100 per individual in prescription drug charges ($300 maximum if you have a family of three or more on one account). Only expenses for Tier 2 and Tier 3 drugs covered by the plan count toward your deductible. For example, if you receive a prescription for a drug for cosmetic purposes (see exclusion 10 on page 47), the plan does not apply this payment to your deductible.

The prescription drug and medical deductibles are separate: Prescription drug purchases do **not** count toward your medical deductible. Medical services do **not** count

toward your prescription drug deductible. See "Your Deductibles" on page 5.

The following costs do *not* count toward your prescription drug deductible:

- What you pay (coinsurance) for Value Tier and Tier 1 drugs.
- Any applicable ancillary charge (see page 34).

Pre-Service

Pre-Service means any claim for benefits under the plan which must be approved in advance, in whole or in part, in order for a benefit to be paid (see also Post-Service on page 112).

Preventive Care

In this Certificate of Coverage, **preventive care** means only those services designated with an A or B rating by the United States Preventive Services Task Force (USPSTF), or immunizations as described on page 27, when received from a professional provider or facility. Services covered under the preventive care benefit are not subject to the medical deductible. You pay nothing for preventive care services when received from a network provider. For preventive care services received from a non-network provider, you pay 40% of the plan's allowed amount, plus any amount the provider's charges exceed the allowed amount (see pages 101–102).

Primary Payer

The **primary payer** is the insurance plan that processes the claim first when a member has more than one group insurance plan covering the services.

Professional Services

Professional services means non-facility medical services performed by professional providers such as medical doctors, doctors of osteopathy, naturopathic physicians, and advanced registered nurse practitioners.

Proof of Continuous Coverage

Proof of continuous coverage refers to the Certificate of Creditable Coverage provided to the member by the member's health plan; or a letter from the member's employer on the employer's letterhead stating the time period the member and his or her dependent(s) were covered by the employer's health insurance.

Provider

A **provider** is an individual medical professional (such as a doctor or nurse), hospital, skilled nursing facility, pharmacy, program, equipment and supply vendor, or other facility, organization, or entity that provides care or bills for health care services or products.

Provider Network(s)

A **provider network** is providers who are contracted to provide health care services to plan members. These providers have agreed to see members under certain rules, including billing at contracted rates (see "Allowed Amount, Medical Services" on pages 101–102). Network providers for UMP Classic members in 2012 consist of Regence BlueShield preferred providers and Blue Cross and Blue Shield plan providers in the BlueCard® program designated as preferred providers, and hospitals contracted with the Health Care Authority.

Quantity Limit

A **quantity limit** is a limit on how much of a particular drug you can get for a specific time period (days' supply).

Regence Service Area

The **Regence Service Area** means the Washington counties of Clallam, Columbia, Cowlitz, Grays Harbor, Jefferson, King, Kitsap, Klickitat, Lewis, Mason, Pacific, Pierce, San Juan, Skagit, Skamania, Snohomish, Thurston, Yakima, Wahkiakum, Walla Walla, Whatcom, and any other areas designated by Regence. Please check the website **www.myRegence.com** for up-to-date information.

Respite Care

Respite care is continuous care for a homebound hospice patient of more than four hours a day to provide family members temporary relief from caring for the patient.

Routine

Routine services are those provided as preventive, not as a result of an injury or illness. In the case of immunizations, routine refers to immunizations included on the Centers for Disease Control and Prevention (CDC) schedules (see page 27).

Scientific Evidence

Scientific evidence means scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes. However, scientific evidence shall not include published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer or a single study without other supportable studies.

Screening

Screening refers to services performed to prevent or detect illness in the absence of disease or symptoms.

Secondary Coverage

When you are covered by more than one health plan, you have **secondary coverage** that may pay a part or the rest of a provider's bill after your primary payer has paid. See "If You Have Other Medical Coverage" starting on page 52 for more information on how this plan coordinates benefits.

Skilled Nursing Facility

A **skilled nursing facility** is an institution, or part of an institution, that provides skilled nursing care 24 hours a day and is classified as a skilled nursing facility by Medicare. Medicaid-eligible, long-term care facilities are not necessarily skilled nursing facilities.

Specialty Drugs

Specialty drugs are high-cost injectable, infused, oral, or inhaled drugs that generally require special storage or handling and close monitoring of the patient's drug therapy (including a few products, such as intrauterine devices [IUDs]). Specialty drugs are identified on the *UMP Preferred Drug List*. See pages 37–38 for information on how specialty drug prescriptions are handled.

Standard Reference Compendium

Standard reference compendium refers to any of these sources:

- *The American Hospital Formulary Service Drug Information*
- *The American Medical Association Drug Evaluation*
- *The United States Pharmacopoeia Drug Information*
- Other authoritative compendia as identified from time to time by the U.S. Secretary of Health and Human Services

Subscriber

Subscriber is the individual or family member who is the primary certificate holder and plan member.

Substance Abuse Treatment Facility

A **substance abuse treatment facility** is an institution, or part of an institution, that specifically treats alcoholism or drug addiction and meets all of these criteria:

- Is licensed by the state.
- Keeps adequate patient records that contain course of treatment, progress, discharge summary, and follow-up programs.
- Provides services, for a fee, to persons receiving alcoholism or drug addiction treatment including room and board as well as 24-hour nursing.
- Performs the services under full-time supervision of a physician or registered nurse.
- Certified by the Washington State Division of Alcohol and Substance Abuse (DASA).

Therapeutic Alternative

A **therapeutic alternative** is a drug that isn't chemically identical to a nonpreferred drug, but has similar effects when given in therapeutically equivalent doses.

Therapeutic Equivalent

A **therapeutic equivalent** is a drug that is chemically identical to a nonpreferred drug and is expected to have the same efficacy and toxicity when given in the same doses.

Therapeutic Interchange

Therapeutic interchange is substitution of a nonpreferred drug by a pharmacist with a preferred drug that is a therapeutic alternative or equivalent, with the endorsing provider's permission (see pages 39–40).

TIP

TIP: To learn more about therapeutic interchange, see "Therapeutic Interchange Program" on pages 39–40.

Tier

Tier is a term that tells you how much you will have to pay for a covered prescription drug. The plan's prescription drug benefit categorizes covered medications into four tiers. See page 33 for details on the prescription drug tiers.

Tobacco Cessation Services

Tobacco cessation services are provided for the purpose of quitting tobacco use, usually cigarette smoking. Only the *Quit for Life* program is covered by the plan. See page 29 for more information.

Uniform Medical Plan Classic (UMP Classic)

Uniform Medical Plan Classic (UMP Classic) is a self-insured health plan offered through the Public Employees Benefits Board (PEBB) Program and managed by the Health Care Authority.

Value Tier

Value Tier refers to cost-effective drugs that are used to treat certain chronic conditions; see table on page 33 for details. For a list of Value Tier drugs, go to **www.ump.hca.wa.gov**, or call 1-888-361-1611.

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When more than one number is listed, the page number in **bold** provides the most detailed information. Numbers in blue indicate information specific to Medicare retirees.